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Syphilis in Eye, Ear, Nose and Throat Practice.*

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No disease is more extensive in its general lesions, nor more universal in its local manifestations than syphilis.

Beginning as a small initial sore it frequently attacks each organ and seriously impairs every function. Bone, nerve and vessel are equally prone to its ravages. The great tripod of life—brain, heart and lungs—furnish fuel for its destruction.

In one of his delightful essays Dr. Osler quaintly advises, "Young man, know syphilis, and what remaineth yet to learn will hardly stretch the pia of the average megalo-cephalic senior student."

In some of its Protean phases syphilis may mask almost any disease. Smallpox, measles, diphtheria, typhoid and tuberculosis are but a few of the many with which it is occasionally confused.

Writing in Pepper's System, Dr. H. C. Wood says: "Every conceivable form of disorder may be produced or aped by syphilis."

Many patients present a condition so perplexing and so contradicto-

*Read before the Jefferson County Medical Society.

ry to their history that only a skeptical attitude and an eagle eye will escape error.

Among the various lesions of the acquired form few are more constant and none more generally recognized than the mucous patches on the lips, tongue and palate.

Inherited syphilis suggests running ears and corneal clouding not less than fissured mouth corners, shoe-peg teeth and snuffles.

We can hardly overestimate the importance of a thorough study of the mouth, nose, throat, eyes and ears in obscure cases where the diagnosis is difficult. This is true of the latent heriditary not less than the acquired form. In half an hour one could scarce enumerate all the conditions which may be present, hence no attempt at exhaustive details shall be made—merely a few important lesions discussed and some illustrative cases reported.

Primary sores—the real chancres—are far more frequent about the head than is generally supposed. My experience embraces two lip chancres—the result of a razor cut while shaving. Both cases had typical sores and presented subsequent secondaries.

Two years ago a fellow student in Chiare's clinic recevied an infection on the occular conjunctiva contracted from a patient with a mucous patches coughing during the throat examination. In Finger's clinic I saw a typical chancre on the upper eyelid of a woman who claimed she was bitten by a lap dog. When told of the true nature of the sore she acknowledged her falsehood and subsequently sent her lover for treatment—probably hoping his bite might become less dangerous.

In private practice one sees few primary lesions about the mouth, eyes and nose unless, perchance, he work in Paris or one of its prototypes where the classical "improper practices" are preferred to the "old fashion orthodox way."

Secondary and tertiary syphilis expresses its commanding presence through the eyes, ears, nose and mouth in many and various forms. The mucous patches may appear on any mucous membrane and, on the lips, tongue and palate—they are familiar to all. When occurring only on

the tonsil, epiglottis or posterior pharyngeal wall they may escape notice or their importance be overlooked. Many years ago Diday and Lancereaux demonstrated that the snuffles of hereditary cases are due to real mucous patches in the nose, and hence a most dangerous source of contagion.

I've recently seen two severe cases of secondary syphilis of the tonsils—referred by members of this society—in neither of which was the condition at all typical. In one case the tonsilar ulcer was the only evidence excepting a single papular syphilide on the forehead. In the other the condition was so acute and the exudative debris so extensive as to simulate diphtheria.

In such cases the greatest care is essential and no effort must be spared to elicit collateral symptoms. The eyes, the post cervical and epitroclear glands, teeth, mouth corners, polyuria, bone nodules, enlarged liver and other conditions may furnish us the essential colors to complete the picture. One must not forget, however, the possibility of a double infection. Such a blunder might withhold antitoxin with fatal results. Immediate diagnosis is sometimes quite impossible.

Specific gumma about the throat and nose sometimes appear sluggish and indolent, but in truth are rapidly destructive, and the remaining scars are extensive and permanent. I have recently seen a patient whose post nasal space was completely cut off from the mouth by the posterior ulcerated surface of the palate growing to the ulcerated mucous membrane of the pharynx. Such conditions, by the way, are exceedingly difficult to cure—even by careful operative measures. In large skin or throat clinics one frequently sees specific gummatous destruction of the epiglottis, chords, laryngeal wall, etc. It was my good fortune to see Kochier do a tracheotomy for laryngeal gumma. After three weeks' treatment the obstruction melted away and the treacheotomy wound was permitted to close.

In all these cases the ulcers are ragged, dirty, foul, and surrounded by an area of intense congestion—thus differing from the shallow "mouse eaten" ulcers of tuberculosis where the mucous membranes are

pale, bleeched out, and anaemic. Specific lesions are sometimes extremely painful while other cases present little discomfort.

The following case of nasal lues is one of a large class:

Mr. E., white, male, age about seventy, consulted me for catarrh. He contracted syphilis in the early sixties, was treated for some months and hasn't had further symptoms. Has raised a large family, several of whom I know, and none seem to have exhibited any suspicious hereditary signs. Although his nasal bridge was entire, much of the septum was destroyed and a large necrosing gumma had melted away, as it were, the left inferior turbinate bone, exposing the left antrum. The right nose showed a large gumma in its roof, which had destroyed much of the middle turbinate, eroded the base of the skull, and exposed a portion of the dura.

The saddle bridge nose is a familiar type and results from gummatous destruction of the septum together with nasal bones and the perpendicular plate of the ethmoid. The odor in these cases is sometimes horrible beyond all description. Fortunately mother Nature often destroys the patient's olfactory powers early in the process.

Specific lesions are frequent in the accessory sinuses. Onodi of Buda Pesth has demonstrated mucous patches in these cavities at post mortem, but the usual lesion is tertiary, and these are a frequent cause of the severe head pain attending specific disease. Unless on guard we are apt to diagnose some pyogenic infection and overlook the real nature of these cases. In puncturing the antrum beneath the inferior turbinate to verify a diagnosis of suppurative disease we may wash pus into the middle meatus and feel our suspicious confirmed, when in reality we have merely removed the foul ichorous discharge from a broken down gumma. We can't be too cautious. A dilligent use of the probe under cocoane and adrenalin, like a blood examination or urinalysis in other cases, is important, but not sufficient. One must search for collateral evidence.

Long before otology arrogated to itself the proud distinction of being a specialty, clinical observers had noted the extensive ravages of syphilis in ear diseases. In one of the publications of the New Sydenham

Society, Lancereaux quotes such cases from Pare, Boerhave, Richord, Van Swieten and others. The latter says, "Sometimes these ulcers, which spread slowly as is their wont, traverse the whole length of the Eustachian tubes and completely distroy the internal ear from which flows an ichorous discharge."

When Von Troelsch Politzer and others began to make pathological studies of ears they found many interesting details:

1. Primary sore of the Eustachian is rare and nearly always results from an unclean eustachian catheter—having occurred six times in a German clinic through carelessness of one assistant.

2. Mucous patches in the tube and middle ear occur frequently and are probably the cause of the running ears so often observed in hereditary syphilis.

3. Gummata in pharynx, postnasal space and in tube cause suppurative ear disease and through direct and destructive extension produce partial and complete deafness.

4. Syphilitic endarteritis (as first demonstrated in the pathological studies of Heubner) destroys the finer vessels of the labarynth, and both in acquired and hereditary syphilis is productive of a slow or sudden but permanent deafness.

While physician for the State School for the Deaf at Talladega I had occasion to see a number of children belonging to this class. In two that I recall the deafness occurred about puberty, was sudden, complete and permanent. This, however, is by no means always the case. Sometimes it progresses slowly with periods of marked improvement followed by relapses with a tendency toward a steady decline. Headache, vertigo, inco-ordination and mental depression are usual accompaniments.

In the eye syphilis finds its most shining mark. Lid, conjunctiva, cornea, schlera, iris, lens, vitreous, retina, muscles and nerve—each and all are frequent sufferers. No organ furnishes more valuable evidence in obscure cases. If in sentiment the "eye is the mirror of the soul,"

'tis no less true in syphilis. Shakespeare says of women's eyes, "they sparkle still the right Promethean fire: they are the books, the arts, the academies that show and contain all." How true is this in the clinical history of syphilis! In the absence of trauchomatous lid scars and a history of injury, any corneal clouding is almost surely a humiliating heritage of ophthalmia neonatorum or a specific interstitial keratitis. The suspicion will be confirmed by rhagades, snuffies, pharyngeal scars, epitrochlear glands, etc. Probably eighty per cent. of all non traumatic iritis is specific. The ophthalmoscope opens a new and beautiful world of syphilitic lesions, from the mildest veiling of the nerve head to the most extensive hemorrhages and atrophy in the choroid, retina and nerve. 'Tis useless to detail the kaleidoscopic pictures presented. In some cases the perimeter is necessary to differentiate between these specific changes and those due to alcohol, tobacco, drugs and hysteria.

The pupillary reactions to light accommodation and skin irritation furnish valuable data not only as to the probable presence of tabes (the classical Argyl-Robinson symptom), but help us locate lesions within the skull.

Writing in "Twentieth Century Practice," Lang, himself a great syphilographer, says, "an eye examination is most essential in all cases of obscure disease." At his suggestion Schnabel made careful studies of the eye ground in forty cases of secondary syphilis and "found normal eye ground in only nineteen. In fourteen of the remaining twenty-one he was able to demonstrate choroidal irritation of different degrees, and in seven found inflammatory processes of choroid or retina or of both membranes.

These changes in the fundus of the eye, which were repeatedly present in the early stage of the general syphilitic infection, frequently attained such a high degree as we find otherwise only in retinitis with total abolition of the visual function, and still the visual disturbance was either altogether absent or only of a subordinate character."

Some years after these observations I worked in Schnabel's clinic under Elschnig and found them still studying all available cases of

early syphilis and frequently venturing a probable diagnosis before the secondaries were manifest.

But the eye specialist has occasion to see another large class of specific cases, where the eye per se manifests few, or perchance no, postive inflammatory changes. I refer to those of brain and meningeal syphilis where there is more or less weakness of some one of the extra ocular muscles. More than sixty-five per cent. of ocular are specific, an dthis condition is often recognized, but the weakening, the early stage, the paresis is easily overlooked. To quote again from Osler, "It is here we must look for what we don't see and listen for what we don't hear." Writing in the last edition of the Hand-Book of Medical Sciences, Putzel says, "sudden development and almost equally rapid disappearence of the occular palsies is very characteristic of syphilitic lesion."

Cerebral syphilis is basilar in the great majority of cases. The basilar meninges are likewise more frequently affected than cortical, and it is in these cases that the nerves of special sense (particularly the optic) together with the motor occuli and abducens are affected. By careful study of the paralysis and its associated symptoms we can often locate a lesion with a fair degree of certainty.

Nausea and slow pulse would implicate the vagus, vertigo the auditory, polyuria the medulla, while hemianopsia of oscillating character would almost certainly mean an extensive basilar lesion. (Oppenheim). Somnolence, impaired memory and lassitude suggest the anterior lobes. Only when the paresis is associated with some form of irritation, spasmodic contractions (epileptic perchance), could we venture on a probable cortical lesion. These early symptoms are especially transitory and fleeting, they come and go. As Heubner says, they are "half and half—half awake, half asleep, half dreaming," half sick, half well.

Epilepsy from inherited syphilis is probably more frequent than we are wont to accept. A careful examination of the eye muscles and the eye ground can often go far in establishing a diagnosis.

The following cases seen within the last three months are illustrative:

Mr. F., W. M., aet. 45. No venereal history. Is somnolent, dreamy, has headache, and aphasia and each disk is slightly swollen, hazy around edges, with a few hemorrhages in each retina. His muscles were weak, his convergences especially defective, his aphasia peculiar in that he would hit and miss the desired word. I feel sure he had a luetic lesion —probably within the brain substance.

A., W. M., aet. 16. Complains of headache and eyes easily tire. Sent to be refracted. His vision was normal. Eye muscles apparently normal when tested singly, but he converges badly. There appears some hitch—some serious defect in his co-ordination of the internal recti. No pupillary symtoms. The eye ground hazy. With much difficulty could the nerve edges be made out. They appear veiled or smeared. Upon inquiry it was learned that he had suffered some years with frequent and prolonged attacks of polyuria and low specific gravity. On this I made a tentative diagnosis of syphilis—note positive of course, but sufficient to justify advising anti luetic therapy with a measure of confidence.

If a patient has partial but insufficient treatment, the specific toxin of syphilis becomes latent, hibernates if you please, and seemingly disappears to manifest itself later when resisting power is attacked by some intercurrent malady. 'Tis quite likely that the syphilitic poison itself impairs resistance, lowers the opsonic index and renders one peculiarly susceptible to other infections or aggravates any weakness already present.

Richord, Fornier and Hutchinson all agree that syphilis with the *milder secondaries* (and hence probably receiving less thorough therapy) is far more likely to be followed by lesions of the nervous system. In early stages the prognosis is faborable. Later, treatment it often a melancholy failure.

The perimeter, opthalmoscope and muscle measuring instruments will often establish an early diagnosis. But when all this is done—when we elicit and study each symptom alone, we must later place it in its proper setting in relation to others and try to view the ensemble. Individual symptoms are mere facts—at best only "pointers." "It is important not to stop at examination of a single system; every organ should be investigated carefully, and taking all into account we will not be often led into error."—(Lancereaux.)

Pyosalpinx.*

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In bringing the subject of pyosalpinx before this society, I would not have you think it is a subject and disease that only concerns the surgeons, for I consider it of more importance for the general practitioner to be well informed as to the symtomatology of this disease than the surgeon, because it is more often up to the general practitioner to make the diagnosis. It is a sad fact that many of the cases of pyosalpinx are treated indefinitely by Vir. Prun. and other like uterine tonics, and the patient permitted to eke out a miserable existence, when a resort to the more radical and rational procedure of removing these pathologic organs, will result in restoring the bloom of youth to the faded cheek, and flesh to the wasted form.

The falopian tube has two openings; one into the uterus, the other into the abdominal cavity, and as the cavity of uterus and abdomen are germ free, the tube will remain so, unless it be by the formation of adhesions between the intestinal wall and tube, the infection travels by continuity of tissue, or through the blood stream, or the lymphatics. Invasion of the tube may take place from either end, but it is usually from the uterine end that this infection takes place. The germs of suppuration usually found, are the streptococcus, staphlococcus, pneumococcus, and bacillus tuberculosis, but it is a conceded fact that the gonococcus is more frequently found than any other micro-organism. In a great number of pyosalpinx the pus is sterile.

Wertheime in his investigations found in 24 cases the products of the inflammation were sterile in 6, 16 contained gonococcis, 1 contained streptococcis and in one he failed to classify the micro-organism.

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*Read before Shelby County Medical Society.

found. One rule he says will always hold good, and that is where the gonoccus is found, the pus is free from any other germ, the gonococcus never being present where we have a mixed infection. The gonococcus is to a marked extent aerobic, cannot long exist without air, and when the process of inflammation and suppuration go on to such an extent as to shut off all ingress of air, then the germ is killed out by its own endeavor to work mischief. This is why we find quite a number of cases of pyosalpinx which contain sterile pus, and this pus cannot be said to be produced by any specific germ as the producing germs have disappeared, but I think this sterile pus is more often due to the gonococcus. We know a large per cent. of pregnant women have gonorrhea. Leopold estimating that twenty per cent. were thus affected.

Sanger, Burckhardt, Oppenheimer and Lomer, the opinion of each being worthy of consideration, place the number of women afflicted with gonorrhea from 18 to 30 per cent. The gonococcus extends by continuity of tisue and seldom attacks any structure deeper than the mucosa. James D. Voorhees of New York says "the effects of the gonococcus are detected for long periods after labor, in enlarged tubes and pelvic peritonitis," resulting in the one child sterility.

As salpingitis always preceded a pyosalpinx; we had best briefly consider this under the same title. We find one of the first changes is a marked congestion of the blood vessels; the tubes will then present a twisted appearance, on account of the mesosalpinx not taking on the congestion and inflammation to so marked an extent as that of the tube. You will find a marked increase in the thickness of the mucous membrane, almost filling the lumen of the tube. In the early stages you may find a tube in which the outward appearance is normal and you may think the symptoms presented by the patient has led to a mistaken diagnosis, but after opening the tube the pathologic condition present will be sufficient to account for the symptoms. By the continued action of the germs present we will either get a chronic salpingitis, or it will result at once in pus formation. When we begin to get a chronic salpingitis the tube will then present gross macroscopical changes; the muscular coat becoming very much thickened and the kinking or twist-

ing being much more pronounced; the lymph is at this stage thrown out and nature endeavors by her remarkable power of walling off an infection, to limit the invasion to the locality surrounding the tube, which results in adhesions between the intestines, ovaries, appendix, uterus and any other structure in the region of the tube affected. The abdominal end of the tube is at once closed so as to prevent the escape of any of the tubes's contents into the abdominal cavity. We will seldom see a case of salpingitis in which the infection is limited to the tube itself; the patient putting off the matter of consulting the physician until other structures have become involved.

SYMPTOMS OF PYOSALPINX AND SALPINGITIS.

We may have some symptoms which we cannot account for by the process in the tube, but if we will consider the conditions that a pyosalpinx will bring on if not dealt with at an early date, then we can account for these symptoms. We know that a catarrhal salpingitis will often produce very slight symptoms and the patient recover without any bad after effects, but pyosalpinx will seldom if ever, result in a spontaneous cure. Your patient may recover so far as the danger to life is concerned, but the adhesions which have resulted from the infection will remain producing symptoms to a greater or less extent.

Symptoms usually found are localized pain and discomfort in the region of the affected tube which may be of a sharp, dull or aching character; the pain may become much exaggerated upon the movement of bowels, or the bladder becoming distended with urine, caused by increased intra-abdominal pressure or from the dragging on some adhesions. The tube is often not very sensitive to pain, may contain quite a quantity of pus, and be greatly distended without the woman manifesting acute suffering. The catarrhal salpingitis may run their course and completely disappear without the patient having consulted a physician, but even in these mild cases we can usually find evidence of them having at one time been present, by a microscopical examination, should we do much work along this line on subjects dying from other causes. Schauta claims he can tell by the character of the pain, the portion of tube involved; thus he says, in the acute colicy pains

you will always find the isthmus of the tube the location of the infection, but I am inclined to believe he is leaving the field of facts and drawing on a very resourceful imagination. Ithink by the intensity of the pain, we can tell if the peritoneum is involved or if the process is confined to the tube, for we know in any infection where the infection extends to the parietal peritoneum we get a very sharp and severe pain, which is due to the fact that the nerve supply of the parietal peritoneum is derived from the spinal nerves direct, sensory fibers being more abundant in this direct supply, than in the nerve supply to the vicus, which is derived from the sympathetic system. The dragging down on bands of adhesions may give rise to neuralgic pains, digestive disorders, hysterical manifestations, or other reflex disturbances. The pain during and just before menstruation is due to the congestion of the ovary and tube which are usually bound or constricted by adhesions. In the greater number of cases of tubal disease, we have an increase in the menstrual flow, although 'tis claimed by good authority, that in tuberculosis salpingitis, we have a diminution in the flow. The subjective symptoms are valuable, but cannot be relied upon without a careful vaginal examination, which some authorities advise to be carried out under an anaesthetic, but I do not think this advisable, as we can usually find out the condition without putting our patient to the unnecessary risk of an anaesthetic and to the danger of too rough handling, of the distended tube with perhaps, a rupture. Before our examination we should have the lower bowel free from feacal matter as lumps in the rectum will often mislead us or cause a prolonged examination. We cannot always after a most careful examination, tell what structures are involved in the process, but we can always determine that we have a mass on one or both sides of the uterus, which we will endeavor to differentiate from a fibroid, hematoma of broad ligaments, appendicitis (if on right side), extra-uterine pregnancy or a uterine displacement. Of course there are other conditions such as displaced kidney, spleen, etc., that may lead one to suspect a tubal involvement, but these are rare. In displacements and fibroids, we will have the symptoms of inflammation absent until the condition be-

comes complicated. In retro-displacements, we will find the cervix pointing toward the pubes or in the axis of the vagina, the fundus will not be found by manual palpation in its normal position of anti-flexion. Myoma or fibroids are painless; their attachments can usually be found and the patient will present a history or more profuse hemorrhage than she will in tubal involvement, and a very important point is, you will not have a leucocytosis in this condition; and I would like to say that I put a great deal of faith in the leucocyte count in all conditions where we suspect pus. I notice the tendency of some writers to claim the leucocyte count as a diagnostic means, to be of no value, but I think the trouble is in the counter and not in the count, when the results have proven misleading.

In determining between an appendicitis and a pyosalpinx the manner of onset is of importance. In appendicitis, the pain is at first diffuse until we get involvement of the peritoneum when it will become local, remaining so until the peritonitis becomes more extensive, when it will spread over the entire abdomen. In appendicitis the leucocyte count is usually very high while in pyosalpinx we may have a normal count (if the pus is sterile) or it will not be as high as we would expect in appendicitis. We usually have vomiting with an acute attack of appendicitis which is not the rule in pyosalpinx.

We often find the right tube and appendix involved at the same time, which Cuneo accounts for, in his excellent work on the Lymphatics, by the chain of lymphatics that lead through the appendicular ovarian ligament, bringing these structures into intimate relationship.

From hematoma we will rely for a diagnosis on the history. Where we have a sudden attack of pain without signs of inflammation with a general weakness experienced by the patient at that time, no increase in our leucocytes and a tumor on either side of the uterus, we would likely be correct in a diagnosis of hematoma of the broad ligaments.

In extra uterine pregnancy the menstrual history together with the lack of inflammatory manifestations would lead one to suspect an ectopic. Here our lecucocyte count may misslead us, as we have a very marked increase in our count. Some of our recent investigators claim

by the deferential count, we can exclude pus as we will have a marked increase in the polly-neuclear cells if it is pus, where we will in an ectopic pregnancy have an increase in the leucocytes as a whole the ratio remaining about the same between the different kind of white cells.

I have not gone into the differential count and only mention it to show that an effort is being made to make the microscope a more valuable diagnostic measure.

TREATMENT.

In our treatment of the condition I think we should do as we would in all others, try and prevent its occurrence. We will briefly refer to the prophylaxis and the two most important prophylactic measures which are arsepsis and antisepsis on our obstetrical work, and properly advising our young men as to the danger to the young wife, should he carry the germs of gonorrhea to the marriage couch. Principles of honor toward the young girl should, together with the knowledge that he may blast her life, prevent a man of honor from contemplating marriage until he knows he is free from the disease, but we too frequently see young men who regard gonorrhea as nothing more serious than a bad cold, and quite a number of physicians encourage these views.

Our methods of preventing the invasion of micro-organisms during the labor are too familiar to you for me to attempt to go into the matter in this paper. One point I think worthy of mention, and that is the use of rubber gloves, and make as few examinations as possible. As to the curative treatment after we have a pyosalphinx, I think this is only surgical, all medical measures being useless, but before we have pus formation we know that under the influence of hot douches, rest, freedom from sexual intercourse, and tonics for the general system, many of these cases recover. A very thorough cleansing of the intestinal tract is important in cutting short an acute salpingitis and I think magnesium sulphate the best purgative in this condition as it has a

tendency to deplete the lower bowell and relieve the congestion in this vicinity.

An ice bag over the lower abdomen is said to exercise an inhibitory action on the accompanying peritonitis and will often relieve the pain.

The ichthyol and glycerine tampon will be found useful, these should be inserted every third day. Put your patient on stimulants such as strychnine and whisky, and you will often get a symtomatic recovery. In the cases that have gone on to pus formation (pyosalphinx) the above remedies will do no good, but here we should deal with the pus as we would in any other locality, which may be through a vaginal puncture or through the supra pubic incision. I never employ vaginal puncture except for an accumulation of pus in the cul de sac. I do not think we can deal with the condition so thoroughly through the vagina as through the abdominal incision, and I am always afraid of surgery in the dark, for often in these conditions we have misplaced blood vessels and adhesions drawing the structure out of their normal relation and if we get a profuse hemorrhage or cut some important structure, we can hardly deal with it from below.

The operation of salpingectomy was performed by Dr. Seydel of Russia in 1784, and the recovery is as perfect as is obtained by our up-to-date surgery of the present age, in spite of the fact that sweet milk was used to moisten the packs that were used in the abdomen.

The method employed by me in dealing with pus accumulation in the tube is after carefully preparing the abdomen, a median incision is made between the umbilicus and pubes. Upon getting in the abdominal cavity, the left hand is inserted and a careful exploration made of the pelvic contents, the intestines are packed or walled off from the pus tube by gauze sponges or packs. One or two fingers are used to break up the adhesions and enucleate the mass from the surrounding structures, and as these adhesions are broken up, I endeavor to have a gauze pack follow immediately behind fingers so that, should a rupture occur, the gauze will at once absorb the pus. The point at

which I most often find we get a rupture, is the attachment of the fimbriated extremity of the tube. When the tube has been enucleated, we bring it out through the abdominal incision and with a Cleveland throw a ligature through the broad ligament near the uterus and ligate the tube and ovarian artery in one mass.

I have employed the method of invaginating the tube just as you do the appendix, but it prolongs the operation and have never seen any good derived therefrom. We now throw another ligature around the ovarian artery in the infundibular pelvic ligament and remove our tube together with the surrounding structures.

While visiting the clinics of the Drs. Mayos, I noticed they always used linen where there was a chance of their material becoming infected and was told by him, that linen was the only material we could use that would heal over in a pus cavity and be completely covered over by healthy granulations. Silk when it becomes infected may form a fistula that will last almost indefinitely so I have on this authority adopted the use of linen in ligations in pus cases. After the removal of structures we then try to cover in all the raw surfaces burying our ovarian stumps on either side in folds of peritoneum, so as to prevent the formation of adhesions with the subsequent evil manifestations.

In the foregoing I presumed we were dealing with an unhealthy ovary and that the corresponding ovary was in a normal condition. Were we to endeavor to preserve the ovary or a part thereof our ligations would be different, but the tecnique the same. As to drainage, we would advise to drain should there have resulted any soiling of the abdomen by the contents of tube, but if we have succeeded in getting the tube out without a rupture there is nothing to be gained by drainage. Kinds of drains employed are the gauze and rubber tube with quite a number of perforations in same. The gauze is covered with rubber to prevent adhesions and left in for several days. It is said that gauze unless changed every 48 hours will not act as a drain, but if we will pour the gauze full of per-oxide of hydrogen it will again do

its work as well as when first inserted into the cavity. One of the most important points connected with drainage is the position of the patient, and the Fowler position would seem the most rational manner of securing the best drainage. We not only put our patients into this position to secure better drainage, but to prevent the infection from reaching the upper abdomen. In making these few remarks in regard to drainage, I am aware I have digressed from my subject, but the subjects of pus in the peritoneal cavity and drainage are so closely allied that we can hardly think of one without the other. Now in conclusion I wish to thank the Shelby County Medical Society for the honor they have conferred on me by requesting me to read this paper, and while I fully realize its incompleteness, still I hope it may bring before your minds the grave condition presented when we are dealing with a case of pyosalphinx, and that a free discussion may be indulged in by the visitors and members of the society, so that we may derive something at least from this discussion.

Some Remarks on the Gonorrhœal and Post-Gonorrhœal Prostate.*

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It is usually granted that a gonorrhoeal infection of the posterior urethra means an infection of the prostate itself; for while the so-called prostatic urethra and the prostate gland are distinct from an anatomical standpoint, clinically an infection of the former necessarily involves the latter, even though to a slight extent; or as Lydston puts it, one "cannot conceive of an acute inflammation of infectious origin limiting itself to the mucfious membrane of the posterior uhethra;" he makes the term "acute follicular prostatitis" synonymous with "acute posterior gonorrhoea." To arrive then at an estimation of the fre-

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*Read before Jefferson county Medical Society.

quency with which gonorrhoea affects the prostate, we could merely take the statistics which give the percentage of gonorrhoeas showing posterior involvement; but as to this we find only the most vague statements. One estimate make 80 per cent. of all gonorrhoeas become sooner or later posterior; another author doubts this, but makes the significant admission that "in view of the careless, routine, and often overvigorous treatment of gonorrhoea, to say nothing of the vicious, self-imposed unhygienic conditions of the patient, it is surprising that prostatic complications do not occur in nearly every case of gonorrhoeal infection." Swinburne thinks careful and early treatment of gonorrhoea may limit the infection to the anterior urethra in all but about 15 per cent. of cases, whereas the 80 per cent. mark is reached in untreated or improperly treated cases. If we are to believe that 80 out of every 100 men contract gonorrhoea, it makes a rather gloomy prognosis to reckon on 80 per cent. of that 80 being afflicted with an infection whose duration and sequelae are so uncertain. Although the picture of post-gonorrhoeal horrors furnished by the quack through the pages of our newspapers and religious journals is much overdrawn, yet the burden of proof is on gonorrhoeal prostatitis for having some part in a long list of varied affections, such as sterility, sexual neurasthenia, prostatic carcinoma, and prostatic hypertrophy.

As to the varieties of acute prostatic inflammations, nearly all writers adopt or copy a classification showing three forms, with varying degrees for each form; the acute catarrhal, the follicular, and the parenchymatous.

By the first form is meant a mere surface inflammation of the urethra, extending possibly to embrace a small area of bladder mucosa; it is loosely synonymous with posterior urethritis as ordinarily assumed.

By the second form, follicular prostatitis, is meant a deeper invasion into the glandular tubules of the prostate, giving multiple foci of infection beyond the mere lumen of the urinary channel. Whether the first form can exist without such follicular involvement, is certainly doubtful, and one view has already been quoted to the contrary; clinically no one could attempt to differentiate the two by saying whether a

given infection had skipped over the mouths of these follicles or had. following the natural course, invaded them for a part of their depth. Such an attempt at distinction, then, is practically useless.

The third form given is acute parenchymatous prostatitis, where we consider the entire substance of the prostate, both glandular and muscular, to be affected by a general inflammation. So intimately connected are the muscle fibres and glandular elements, that it is only necessary to suppose a very acute and very virulent infection invading the posterior urethra, in order to imagine the entire prostate as an inflamed mass, on the verge of suppuration; and if now there is added a mixed infection, possibly through the rectal walls, we may have as the most severe result a true prostatic abscess. The term "true abscess" is used, because some authors describe as a "pseudo-abscess," a collection of pus occurring in one of the prostatic follicles after occlusion of its urethral mouth. Just as the general or large prostatic abscess might be considered to be the end-result of general parenchymatous prostatitis, if sufficiently severe, so might we consider these pseudo-sbscesses to be a probable termination of such infection as invades only the mucosa and prostatic follicles.

It is to these follicular abscesses, largely under-estimated as to frequency and importance, that I desire in this paper to call particular attention; to their formation, symptomatology, and course. They are mentioned time and again in all works on gonorrhoea, but are stressed very little if at all; so that clinically a man with posterior gonorrhoea is said loosely to have "trouble in his deep urethra" unless it be very severe, and then he is "about to have an abscess;" no distinct grades or forms of infection are recognized.

I believe that the formation of these multiple small or follicular abscesses is fairly frequent, and beg to call attention to a few points in this connection. It is estimated that there are in the prostate from 30 to 50 of these tortuous tubules, opening through a small lumen on the floor, chiefly, of the prostate. They normally secrete a glairy fluid of slightly acid reaction. Any infection of the deep urethral mucosa means a hyperaemia sufficient probably to close the months of these

tubules; but in all likelihood the infection has already descended into the follicles, to attack the secreting cells; a mixture of thick fluid and epithelial debris results, which cannot escape through the narrowed orifice. This collection increases in size, and in itself is sufficient by distention to cause pain, particularly when after micturition it is squeezed upon by the surrounding muscular fibres. Two or more adjacent abscesses of this kind may it is said unite to form a larger prostatic abscess; I think it more often happens that an acute general prostatitis on subsiding leaves several follicles occluded, and filled with inflammatory secretion; this has seemed to occur in my experience at least twice in cases where a general prostatic abscess was barely averted. One of these follicular or pseudo-abscesses may intrude upon the lumen of the urethra, and suggest its presence by interference with micturition; if so protruding, it may be ruptured by the passage of a sound or even a soft catheter. Spontaneous rupture, however, is the rule, and the germ-laden pus so liberated may set up or renew infection in a neighboring follicle or in the ejaculatory ducts. The cavity left in the abscess-site may continue indefinitely to harbor colonies of gonococci, or may granulate up and heal.

A succession of these unfortunate little set-backs is thus likely to occur, alternating with short periods of almost entire freedom from symptoms; a prognosis to be borne in mind by a too-optimistic surgeon or patient. The symptoms attending these abscesses closely simulate those seen in what is variously termed a relapse, recurrence, or recrudescence, of the primary infection, and their distinction is important for more than one reason. First, a recrudescence without apparent cause is more than apt to be due to some indiscretion on the part of the patient or lapse of vigilance on the part of the surgeon, whereas one or more follicular abscesses may develop in spite of all precautions,—although the surgeon *is* responsible for their cure and *partly* responsible for their recurrence; secondly, a recrudescence is often merely anterior, and its appropriate treatment would not touch a follicular abscess or its site.

Since certain prostatic symptoms, both subjective and objective, may accompany their existence, I would like just here to insert a word or

so as to the findings obtained by rectal examination of the prostate in gonorrheics, and in post-gonorrhoeal conditions as well; for this diagnostic aid, so often omitted, may lead to error almost as often as it would afford positive knowledge.

In the acute forms, we have of course the swollen, hot, doughy, and extremely tender prostate of general or parenchymatous prostatitis, with perhaps fluctuation should a large prostatic abscess supervene. But in mere follicular prostatitis, even with one or more follicular abscesses present, the objective and subjective signs may vary but little from those in the normal prostate. The abscesses may be felt indistinctly as rather hardened nodules, or they may be so near the urethra and so far from the palpating finger as to be unrecognized. In other cases, where nearly all the follicles are occluded and distended, the prostate may be much enlarged, very hard, and yet not particularly tender; the same prostate, after resolution or rupture of these follicles, will become smaller, with hardened areas among those of normal consistency, until finally all of these collections are made to disappear.

In post-gonorrheal conditions, we have those patients who while retaining a normal sexual balance are afflicted with certain disorders referrable to an old gonorrhea, and possessing what different authors term a chronic prostatic catarrh, or an irritable deep urethra; in these the prostate may be normal in size, with perhaps a slight over-sensitiveness to pressure, and nothing more. But in those who are well-developed sexual neurasthenics or hypochondriacs, with vague and improbable symptoms, the prostate is often found to be quite small, as if undeveloped or atrophied; and this suggests the theory that in such patients the former gonorrhea may have been a mere incidence, while some lack of functional action or secretion may have to do with their mental and sexual state.

Returning to follicular abscesses, their exact frequency is difficult to estimate, since it may be impossible to detect their presence before rupture, and such signs as attend or follow rupture are quite apt to be overlooked. A brief outline of a typical case will serve to show the way

in which such an abscess becomes manifest, and also in part its differential diagnosis from some other conditions with which it is too readily confounded, such as general prostatic abscess, anterior folliculitis, and a recrudescence.

A patient, who has had a rather severe infection both anteriorly and posteriorly, first ceases to show active anterior trouble, and finally after anterior irrigation presents urine which is perfectly clear and free of everything save perhaps a few shreds; it continues so for several days. Rectal examination of the prostate reveals nothing suspicious, for the abscess is no larger possibly than ap ea, and is some distance from the rectal surface of the prostate. One morning, say at 9 a. m., there is no discharge, and the urine is clear; the patient remarks on an itching, uneasy, but not painful, sensation in the perineal region, noticeable for the past 24 hours. A few hours later, the patient returns, because without warning, or it may be following a sensation as if "something had burst," he finds several drops of a very thick, brownish or blood-tinged pus escaping or about to escape from the meatus; on cleansing the anterior urethra by irrigation, the entire bladder urine is found quite cloudy from the same purulent debris. The bladder is thoroughly irrigated; the patient returns late the same day or the next morning with no discharge, with clear urine, except perhaps more shreds, and with a relief from the perineal sensation previously felt. There had evidently been a sudden escape of a small pus-collection from some region posterior to the external sphincter or "cut-off," with the discharge of a certain portion anteriorly through the relaxed sphincter, and of the larger back into the bladder. Except for careful watching on the part of the doctor and patient, before and after, this could well be taken for a recrudescence as above mentioned, and treated accordingly; as a matter of fact, it may often set up such a re-infection, or start another follicular abscess, or a seminal vesiculitis or an epididymitis; therefore it must be treated promptly, energetically, and as nearly locally as possible. A rapid closure of the pocket remaining is of course favorable, and does often occur; if it remains however as a cavity, with difficulty accessible to treatment, it becomes, I believe,

our most frequent focus of chronic or latent infection, liable to cause relapses or infection in others at some future time.

Our treatment of subacute and chronic prostatic infection should be logically such as would first tend to open and keep open the tubules or follicles, with promotion of resolution; and lastly and of less importance, the local application of antiseptic or stimulant drugs. These results are to be attempted through prostatic massage, hot rectal irrigations, suppositories, passage of sounds, and prostatic applications through soft catheter or instillation syringe; all measures must however be guarded and gauged to the individual case and the proper time with especial care, since ill results may be obtained with considerable ease in spite of such opportunity for doing lasting good.

Annual Message of President.*

By J. F. Jenkins, M. D.

Piper, Ala

Gentlemen of Bibb County Medical Society:

My year's service as your president is ended. I have deeply appreciated the honor of serving you in that capacity, and have tried to express my appreciation by laboring in season and out of season for more interest and harmony in our society, for better medical papers and more liberal discussion of medical topics at our sessions in order that our coming together might be the more attractive to the members and all friends of medicine. The medical society should be a general school for the practicing physicians, where their experiences are compared with their fellows, their mistaken views combatted, their useful ideas tried by others, where the barrier of suspicion against brothers in medicine is melted by the social warmth of greeting and discourse.

It is not considered good taste to discuss fees in our society meetings as our society is not intended ever to act as a trust to corner our ser-

*Read at Bibb County Medical Society meeting, Jan. 1, 1907, Centerville, Ala.

vices to sell them to better advantage. But I cannot refrain from commending the action of many of the doctors in this county and in fact in all parts of the United States in refusing to accept the reduced fee schedule of some of the old life insurance companies. For in dealing with insurance companies we are not dealing with the sick and afflicted where always charity and the milk of human kindness should be ever present in our mind, but we have a simple business proposition to consider. The insurance companies want experts to give opinions as to the character of their risks, just as any other corporation about to enter upon any other venture, say opening a coal mine, would want the opinion of coal mining experts as to the character and amount of coal expected to be found. These combinations of men and capital are organized purely for financial gain. As a business proposition they need the services of physician, and arbitrarily fix the price they propose to pay for such services. If the physicians act together the insurance companies will have to pay a reasonable price for the service rendered. But pardon my digression.

Our society has held its four regular meetings with good attendance. The papers read and the discussions that always followed could not but have been beneficial to those who were present. In one of the meetings the laity and profession were alike invited and allowed the floor, and I cannot but feel that such meetings are for the general good, for we have duties besides self-improvement and our own pleasure. The people and the medical profession are too much estranged in many matters. Many are inclined to look upon our noble profession as a trust, interested only in the aggrandizement of its members. And while such sentiments are entertained we cannot measure fully up to our duties. Our profession is truly altruistic, and while often our immediate duty is the alleviation of suffering, yet our highest duty is the prevention of diseases. How ignorant the people are in matters of the care of their bodies in health and disease only the physicians know. The great majority of human ailments are entirely preventable. Every seventh death is due to tuberculosis, a preventable disease. Typhoid fever annually claims many victims who are ignorant of the necessity for pure drink-

ing water. Seventy per cent. of the operations done on pure, innocent women, are for the ravages caused by the gonococcus, which their lords and masters contracted while sowing their wild oats. Time does not allow me nor will I insult your intelligence by further enumeration. What are our duties? To teach the people and save them from their ignorance. By showing and striving to have removed from the communities in which we live the causes that breed disease, stagnant pools of water, all human and animal excreta and all filth in general; by having a supervision over the water supply, recommending that which is good and condemning that which is impure; by having a vigilant eye over the especially contagious diseases, as smallpox, scarlet fever, diphtheria, etc., and ever ready with isolation and inoculation to arrest their spread.

Take the people more into our confidence in treating their troubles, tell them what results we expect from a given treatment, abstain from prescribing any secret or proprietary remedy, and better still prescribe no combination of drugs but such as is our own devising to meet certain definite conditions. If we allow pharmaceutical houses to do our prescribing for us, we debase ourselves as physicians and become mere dispensing clerks.

In open meetings the frauds, evils and doings of the nostrum business, the evils and devices of the advertising quacks and the traveling fakirs, could be exposed and the people informed. At the meetings invite the representatives of the county, discuss the necessity for pure food and drug laws, lend an encouragement to any law that places a safe guard of purity on the food and drugs that are consumed by the American people, then every bottle of peruna, electric bitters, cooper's medicine will have on its label such a per cent. of alcohol, so much dope. If a patent medicine is good for anything let its formula be printed on the label, if it contains poisons, let *Poison* in red letters be put on it. Let it be advertised to cure only those diseases in which it is really curative.

Again to lessen the seeds of syphilis and gonorrhoea that lurk amid the floral offerings at hymen's altar should be a never ceasing endeavor.

Teach the young men the beauty and possibility of sexual adstinence in adolescence that in manhood and age the strength and endurance of their virilty may be enhanced. Teach them the suffering that unlicensed gratification may bring them, their future wives and children.

Let us lend our aid and encouragement to secure laws that will guarantee safety in the marriage contract. Without a certificate of health signed by three reputable physicians, no young man should be allowed to lead to the altar the innocent women of our land. And until such is a law let us impress upon our specific patients their barriers to matrimony. Never give our consent and advice to marry in gonorrhoea cases till five months have passed without signs of symptoms, and in syphilis cases let five years be the durance vile with two or three years of treatment.

Gentlemen, it is my belief, that for the medical profession to command its full importance in the social fabric, we must concern ourselves more about the public, who are dependent upon us for protection—then, and then only, will our society attain that vitality and strength which rightly belongs to us.

WIN AGAINST TUBERCULOSIS.

A late dispatch from Berlin says: A decrease since 1875 of 38 per cent. in the number of deaths from tuberculosis is shown in the returns furnished by the National Tuberculosis Congress. Sanitaria have restored to health and work 34 per cent. of the patients treated. During 1905, 26,621 persons coming under the workmen's insurance act were treated at sanitaria.

The insurance companies of Germany from 1901 to 1905 spent $9,000,000 in fighting tuberculosis. The outlay included the establishment of twenty-six sanitaria with 211 beds for women and ten sanitaria with 541 beds for children. All these were due to the suggestion of the Empress.

The results attained at dispensaries were also excellent. Thus in 1905, 15,161 persons were examined in Berlin, and 8200 apartments inspected and modified so that a person infected with disease could be isolated completely.—The Medical Bulletin.

Society Reports.

REPORT FROM BIBB.

The Bibb County Medical Society held its regular meeting at Centreville, January 1st, 1907. The programme for the meeting was nicely gotten up and sent out a few days previous to all the doctors in the county and to many of the doctors friends. And there gathered at Centreville on the day appointed at 8 a. m., about fifteen doctors and as many of the laity, prepared to take part in the programme, a bird hunt from 8 a. m., to 4 p. m. This hunt, although a novel idea for such a gathering, was much enjoyed by all participants and the Medicos proved themselves first class marksmen by piling up a score of one hundred and fifty quails.

At 7 p. m., the society was opened for the regular programme in the parlors of the Wardsworth House. The President, Dr. J. F. Jenkins, read the annual message which brought out some discussion on insurance fees, and while no regular action was taken by the society, yet it was evident that only those insurance companies who pay the $5.00 fee for examination will do any work in Bibb.

As the January meeting was the regular time for election of officers the Society went into the election, and the following doctors were elected to the respective offices:

President—Dr. J. F. Alexander of Blocton.

Vice-president—Dr. J. S. Williamson of Coleanor.

Secretary and Treasurer—Dr. W. J. Nicholson of Centreville.

Health Officer—Dr. L. E. Peacock of Blocton.

Censor for the full term—Dr. T. E. Schoolar of Centreville.

Censor for two years term—Dr. S. C. Meigs of Centreville.

After election of officers the scientific papers were taken up. And Dr. J. F. Alexander presented an able paper on "Catharrhal Enteritcs" which was freely discussed.

Dr. C. P. Martin presented a useful and instructive paper on "Eclampsia," which brought out some experiences from the doctors present.

After the regular programme the doctors repaired to the banquet hall where a bountiful repast etnriched by one hundred and fifty quail on toast was served to the satisfaction of the most exquisite epicure.

MADISON COUNTY SOCIETY.

The annual meeting of the Madison county Medical Society was held Monday afternoon January 7th, in Huntsville, and officers for year were elected as follows:

Dr. B. E. Graham of Gurley, President.

Dr. J. J. Horton of Huntsville, Vice President.

Dr. Edgar Rand of Huntsville, Secretary.

Dr. W. C. Wheeler of Huntsville, County Health Officer.

ETOWAH COUNTY SOCIETY.

The Etowah County Medical Society met in Gadsden on January 1st, and held the annual election of officers:

President—Dr. E. T. Camp, of Gadsden.

Vice President—Dr. J. P. Stewart of Attalla.

Secretary—Dr. S. T. Acker, of Gadsden.

Censor— Dr. E. S. Jones of Gadsden.

The Society by resolution condemned the action of those insurance companies who propose to reduce the fees for examinations and declined to accept any reducction of fees.

SHELBY COUNTY SOCIETY.

The Shelby County Medical Society met on January 8th. Three new members were elected to membership, Drs. Payne, Reid and Bickley. The following officers were elected for 1907:

President—Dr. W. C. Williams, Shelby.

Vice President—Dr. B. H. Smothers, Redlawn.

County Health Officer—Dr. J. H. Williams, Columbiana.

Censor—Dr. W. C. Williams, Shelby.

Censor—Dr. O. E. Black, Wilsonville.

A resolution was unamimously passed expressing regret at the removal from the county of Drs. C. T. Acker, W. H. Bell and J. C. Walker and the Secretary directed to write commending them to the Etowah and Jefferson County Societies. A resolution was passed, and a copy of the resolution ordered to be sent to each doctor in the county, signed by all the doctors, agreeing to make no old line insurance examinations for less than $5.00 and no fraternal life insurance examination for less than $3.00.

At the suggestion of Dr. Gunn, the Society contemplates for the year 1907, taking up some drug or therapeutic measure each month, testing or trying it on appropriate cases during the month and having each member report in writing at the end of the month, his observations.

RESOLUTIONS OF SHELBY COUNTY MEDICAL SOCIETY ON FEES FOR LIFE INSURANCE EXAMINATIONS.

Whereas, The American Medical Association has strongly advocated concert of action upon the part of doctors all over the U. S., in reftically ruled that it is not contrary to their constitution, and

Whereas, The Medical Association of the State of Alabama has practiccally ruled that it is nat contrary to ther constitution, and

Whereas, Many doctors in Alabama have already agreed to the following schedule of fees, there be it,

Resolved, That we request all the doctors in Alabama who will agree to make no old line life insurance examinations for less than $5.00, nor any fraternal life insurance examination for less than $3.00, to forward their names to the editor of the Alabama Medical Journal with the request that he publish their names, together with their uost office address, under the resolutions upon this page until all the names that can be secured are recorded. The following physicians in Shelby county have agreed to this in a resolution adopted at Calera, Ala., January 8, 1907: D. L. Wilkinson, M.D., Montevallo,

Ala.; J. H. Gunn, Md., Calera, Ala.; B. H. Smothers, Md., Wilsonsonville, Ala.;; O. E. Black, Md., Wilsonville, Ala.; I. J. Bickley, Md., Calera, Ala.; J. H. Williams, Md., Columbus, Ala.; W. C. Williams, Md., Shelby, Ala.; J. I. Reid, Md., Aldrich, Ala.; J. R. Morgan, Md., Shelby Springs, Ala.; T. H. Payne, Md., Saginaw, Ala.

THE PERILS OF THE AROMATIC ELIXIR.

The simple elixir, or aromatic elixir, as it is now denominated in the Pharmacopœia, is a preparation that probably most of our brethren look upon as an innocent vehicle with some approach to palatability, and it is one that many of them must prescribe freely under the influence of that impression. But let us consider. Our readers ought to know that we have no particular sympathy with the extreme tenets of the Woman's Christian Temperance Union. Nevertheless, we dislike to contemplate the probability that physicians often prescribe unwittingly a considerable amount of alcohol when they order the aromatic elixir of the Pharmacopœia, and to reflect that it is particularly for children that the elixir is prescribed. A pharmaceutical friend reminds us that the elixir contains almost as large a percentage of alcohol as is to be found in brandy or whisky. Inasmuch as the elixir is largely ordered as a vehicle for a sedative, it is easy to perceive that its own action, by virtue of the alcohol contained in it, may readily overcome that of the sedative and prove positively injurious on that account.

But that is not all. At the recent annual meeting of the Pennsylvania Pharmaceutical Association Mr. E. G. Heffner, of Lock Haven, read a paper in which he pointed out another danger incident to the indiscriminate prescribing of the elixir as a vehicle for the bromides, in which character, we cannot doubt, it is often ordered, and very frequently in mixtures containing chloral hydrate. Mixtures of a bromide and chloral hydrate, says Mr. Heffner, are prone to undergo decomposition in the presence of an alcoholic preparation, the result being the formation of the dangerous body known as chloral alcoholate. This is a liquid of such a specific gravity that it floats on the top of the mixture, and unless a "shake" label is placed on the bottle the patient may get the whole of the chloral in the first dose or two. It is best to order chloral to be dissolved in a simple aromatic water, in syrup of orange with orange-flower water, or in aqueous solution to be diluted with milk.—New York Medical Journal.

Editorial.

W. H. BELL, M. D., Editor.

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Pneumonia.

We, at this time of the year are confronted with that deadly foe to humanity—pneumonia. In spite of our various "specifics" and the "do nothing" idea, this d sease still claims about the same number of victims each year as it did during the days of Hippocrates, who defined pneumonia as "an inflammation of the lungs, characterized by various colored sputa." And this learned man at once adopted rational measures for its relief, and the success crowning his efforts was as good as is often obtained by many of us at the present day.

The doctor who claims that there is nothing to be done in the

treatment of a case of pneumonia, had better remain at home and let the patient take his chances in relying on a good constitution and the mercies of God, and save the doctors bill.

The medical man who is constantly searching for the specific, or the remedy that will at least ameliorate a disease is the progressive medical man. We know that many remedies have been for a time lauded as curative in this disease and after thorough trial have been discarded as useless. But this has been the case with most diseases. It may not always be the remedy at fault; the fault may be in the dose or in the purity of the drug. For instance, one man will say he is getting excellent results form creosote; while another will claim nothing accomplished by the use of this drug. The one will administer it to a adult in 3 to 5 minim doses, and use a crude drug, which is merely a bi-product in the process of manufacturing creosote; while the other will use the pure drug in 20 minim doses and obtain good results. We do not claim that creosote is a specific, but are quite sure in many cases it has done great good. The only pure creosote on the market that has produced results in our hands, and that will come up to the chemical test, has been a product of a London house, and made according to the Pharmacopoea of 1885. The same firm manufactures a cheaper creosote, which is used as these other bi-products are in nearly all drug stores to fill prescriptions; but it takes the precaution to state that it is not pure creosote, but is make according to the Pharmacopoea of 1898. We would not give 20 minims of the creosote ordinarily used in filling prescriptions; but have seen pure creosote given in 100 minim doses without evil effect. In a very interesting paper read at a meeting of the American Medical Association in 1901 by Dr. Jas. A. Buroughs of Asheville, N. C., he relates his experience of nineteen years in the treatment of tuberculosis with creosote, and his results were most flattering. He claimed that it is only by the use of large doses of creosote that we can expect good results; and that while he has never used it in pneumonia, he did not doubt but that it would exercise a beneficial effect on the disease, as it is very freely excreted by the lungs. Another drug found very useful and claimed by some

to be a specific in the disease is quinine given in very large doses, 60 to 80 grains. These large, disagreeable doses constitute an objection to its use. Quinine is not a very pleasant article of diet, and 80 grains is quite a full meal. Another objection to its use is that it will inhibit a leucocytosis, or perhaps cause the leucocyte count to fall below the normal. As the leucocytes are very essential in all forms of bacterial invasion we would think any drug that would prevent nature's effort to protect herself would be contra-indicated. However, good results are reported from its use, and we should not condemn it until it has been tried thoroughly by good men and found to be useless.

The latest method of treating pneumonia being advocated, or rather tried, is surgical. Two of our most prominent surgeons are claiming excellent results from cutting down to the congested area and draining. This, they claim, will furnish not only a relief for the congestion of the organ, but a ready exit for many bacteria that would otherwise have to be taken up and cared for by the general system. This method is in its infancy, but may produce very flattering results.

The one point we would like to emphasize is, let us not ridicule the doctor who thinks he can do something for this disease; but let each hope and strive and look forward to the day when we can go forth to the pneumonia battle ground and feel that the enemy can be overcome, or better still, prevent the necessity of battle; and not sit down in the seat of the therapeutic nihilist, fold our hands and say "let nature take her course."

Unselfishness of the Medical Profession.

A fact, referred to in his speech at the Annual Banquet of the Jefferson County Medical Society recently by Dr. R. M. Cunningham, illustrates the unselfish tendencies of the organized medical profession. In the recent campaign for governor, Dr. Cunningham, an honored member of the profession, once the president of the State Medical Association, was one of the two candidates. And yet no organized effort on the part of the profession was made in his behalf. While

we believe that a great majority of the doctors of Alabama gave him their support, yet the organized profession as an organization did not take action for him. This but illustrates the unselfishness of the profession, although it is generally thought by many of the laymen that the organization exists for selfish ends. This idea prevails probably because organizations of the profession and other classes of men are different. They do not hesitate to endorse by official action men from their ranks, who seek political preferment. One striking instance of this was where some years ago one organization turned itself into a political party in the interest of a leading member.

Another illustration of the altruistic tendencies of the medical profession is the fact that the profession is doing all it can, individually and in an organized capacity, to prevent disease.

They ask our legislators for the enactment of laws that have this for their object.

Strong efforts on the part of the organized profession have been made, and will continue to be made, to have the legislature enact laws giving sufficient salaries to County Health Officers to enable them to give more time and labor to the prevention of disease. And only those who have been instruments in endeavoring to secure this legislation know the difficulty in overcoming the idea in the minds of even our legislators that our organization is a trust, whose only object is for the procurement of financial benefits to the members. The fact that the prevention of disease means less income for the doctor seems never to occur to the selfish minds of many of the laity.

An effort will be made to get the present legislature to pass a law to pay adequate salaries to our health officers. Let every doctor of Alabama come to the rescue and use every influence possible with his representatives in both houses to stand by and fight for the passage of this law. The address of Dr. McCormack, before a joint session of the legislature a few days ago, delivered in his own inimitable way, and coming from one not personally interested, we feel sure has done a great deal to prepare those hearing it to heed the requests of their medical constituents.

Report of the Insane Hospitals.

We are in receipt of the consolidated Report of the Trustees of the Alabama Insane Hospitals: The Bryce Hospital, Tuscaloosa, and the Mt. Vernon. After giving tabulated statistical reports, etc., Dr. Searcy, the Superintendent makes some important suggestions. He refers to the mentally deficient paupers, and says, "How to reach the matter in our State and provide for the mentally deficient as well as those mentally defective, is an absorbing and urgent question. The necessity in our section, for providing separately for the negroes, complicates every public beneficiary work, and adds to its expense. Certainly much can be done towards helping the matter by improving the county care of the mentally deficient paupers. To do this, I know no better plan that will gradually lead to it, than the appointment of a State Inspector of County Alms-houses, who should be a man instructed as to how such houses should be built and managed. He should be authorized systematically to visit every county Alms-house, give such information, advice, and instruction to the County Commissioners as they will receive; make each Board a written statement as to the comparative condition of their alms-house, which statement should also be made as a public report to the Governor. This would attract attention to such work in the State, and eventually by reason of enlightened public opinion, lead to an improvement that would relieve the State institutions of much of the care of the deficients. State care is always the best, because it is prominent and open to widest inspection and criticism. Still county and municipal care, I think in this way, can be improved. If the State wishes to take up the care of all the mentally impaired persons, white and black, within her borders, she will have to make provision for at least 3,000—steadily increasing."

In discoursing on the drug and drink habits, he says, "Public instruction is much needed on these subjects. In State legislation for the restraint, care, and treatment of chronic alcoholics and drug habitues, where they have reached such a degree of mental defectiveness that they have become insane, that is, offensive, troublesome, or

dangerous to others, it is best to recognize, in the expression of the law that they are objectionable members of society, and proceed against them in the same way as against offending criminals. It is best to have special legislation for them; to have them tried by a jury, and sentenced to an institution for their care and detention for a definite term, not less than three months, oftener six or twelve months, or longer, according to the grade of their alcohol or drug habit; with an increased term of detention if they relapse after liberation. Their own safety and the welfare of others demand that such persons be removed from society; they are often as offensive, troublesome, or dangerous as the most insane. When a congenital neurasthenic becomes a drug or drink habitue, his cure is very difficult, often impossible. When sent to the insane hospital under the usual committing certicate by the Judge of Probate, in the majortiy of cases, it is impossible to detain inebriates or drug habitues long enough to make a cure; they demand to get out, and then they, as a rule prove very objectionable patients to associate with the others. Separate provisions ought to be made for them, and special legislation ought to be obtained for restraining them, The present law for the insane does not cover their cases. Every day experience in the management of an insane hospital exhibits the necessity for additional legislation respecting the drink and drug cases."

Doctor Bragg's Report.

The bi-ennial report of Dr. Shirley M. Bragg, President of the State Board of Convict inspectors of Alabama has produced a big sensation in the state

It certainly contains some facts about the care of the convicts and about the condition in which the jails are kept that should stir up the people. These facts show the county convict system to be a disgrace to our state and should cause the legislature of Alabama to thoroughly reform the system, or wipe it out altogether. Dr. Bragg questions the moral right of the State to work its convicts in the

mines six days in the week. He says that according to the present system the board has no power to transfer a county convict, and if he develops tuberculosis or any other disease, he cannot be returned.

In regard to the jails he says:

"It would be more humane and far better to stake the prisoner out with a ring around his neck like a wild animal, than to confine him in places that we call jails, that are reeking with filth and disease, and alive with vermin of all kinds. They are not only harbingers of disease, but they are unquestionably nurseries of death. To see a man strong and healthy go to a jail in Alabama and in a few months come out a physical and mental wreck, with death staring him in the face, is not an overdrawn picture, and one seen more often than the general public would believe. The state appropriates 30 cents a day for feeding of prisoners, and yet we receive prisoners from these same jails who are on the verge of collapse for the want of nourishment. Surely there must be some way of reaching those in authority. There should be a jail inspector, perhaps two, with the power and authority to see that these places are kept in proper condition and that prisoners are properly fed. These inspectors should be men who know something about sanitation, and above all who would be fearless in the performance of their duties.

"I tell no secrets when I say that in many jails of the State men and women remain for months without means of washing their face or hands."

No one doubts the truth of the statement made by Dr. Bragg, and we hope that the present legislature will introduce such measures of reform as will do justice to this unfortunate class of human beings.

Life Insurance Fees.

The Journal has been requested by a leading doctor, a member of one of our County Medical Societies to devote a page to the names of all the doctors of Alabama, who will forward them to us and who will agree to make no old line life insurance examinations for less

than $5.00, and no fraternal life insurance examinations for less than $3.00.

We will be glad to publish the names each month of the doctors in Alabama who will make this agreement. The doctors in some of the counties have already taken action on this matter. Let all the doctors, individually and as Societies send in their names, so that we may all know who are in favor of fair compensation for life insurance examinations.

The Annual Banquet.

The annual banquet of the Jefferson County Medical Society, held at the Hotel Hillman, Birmingham, Ala., on the evening of December 29th, 1906, was a most enjoyable occasion.

After an elegant feast the toastmaster, Dr. B. L. Wyman, the recently elected president, in a happy manner introduced the speakers. The addresses were all good and enjoyed by the members present.

The program follows:

"The Jefferson County Medical Society, Its Past, Present and Future." ..... Dr Lewis C. Morris.

"The State Board of Censors, the Backbone of Medical Organization in the State."..... Dr. S. W. Welsh, Talladega.

"Civic Government in its Relation to Sanitation and Preventive Medicine"..... Alderman J. C. Forney.

"Medicinal Ethics and Ophthalmology"..... Dr. S. L. Ledbetter.

"The Rise and Fall of Medical Jurisprudence"..... Sterling A. Wood.

"The Doctor in the Eye of the Clergy"..... Rev. Dr. J. W. Stagg.

"The Southern Medical Association" Dr. H. H. Martin, Savannah. Ga.

"The Doctor and His Relation to the Lawyer".. Senator N. C. Miller.

"The Doctor as a Public Servant"..... Dr. R. M. Cunningham.

"The Doctor at a Citizen"..... William Ryan.

"The Press" ..... Eli P. Smith.

"My Experiences with Doctors in Birmingham and Elsewhere..... Richard F. Johnston.

Public Health.

The matter of safeguarding the public health is one which will command your consideration, and in this connection I desire to call your attention to the statement recently made by an eminent medical authority that one-seventh of all the deaths in Alabama annually are caused by tuberculosis, commonly known as consumption, and that not fewer than 15,000 persons in this state are now afflicted with this dreadful disease. Progressive states in all sections of the country are legislating for the prevention and suppression of the "great white plague," and I commend this subject to your earnest consideration.—Extract from Gov. Comer's message to the Legislature.

The Committee on Public Health in the State Senate as appointed by Lieutenant-Governor Gray is composed of the following gentlemen: Messrs. Wimberly, McWhorter, Horton, Lusk, Peacock, Reese and Glenn.

With Dr. Wimberly as Chairman and Dr. McWhorter, the President of the State Medical Association, both physicians on the committee, we hope such medical legislation as is desired by the profession of Alabama may be safely and quickly enacted by the Senate.

Dr. M. C. Ragsdale, of Jefferson county, has been appointed Chairman of the Committee on Public Health in the House. He will be strenuous in looking after the interests of medical legislation in this branch of the legislature. So the medical profession can expect good results at the hands of our law-makers this year.

The Post Graduate Course in County Societies.

We are indebted to Dr. J. N. McCormack for a copy of the program of the Post Graduate Course of the Warren (Ky.) County Medical Society. We can see no reason why every County Society in Alabama can not have a similar Course.

Comparatively few of the doctors of Alabama can visit the larger cities that are the medical centers of the United States for a Post Graduate Course. But every doctor in the State could derive great

benefit from a course similar to that of Warren (Ky.) County Society, if the County Societies of Alabama will organize it and carry it out. We hope that the efforts of Dr. McCormack will bear fruit in the counties that he visits. We give below the program for October 1906:

POST GRADUATE COURSE.

October 2, 1906, *at* 8 *p. m.*

Anatomy of the Appendix .....Dr. E. A. Cherry
Intussusception .....Dr. B. S. Rutherford
Valvulus .....Dr. D. A. Campbell

CLINICAL MEETING.

October 9, 1906, *at* 8 *p. m.*

REGULAR MONTHLY MEETING.

October 10, 1906, *at* 10 *a. m.*

Intestinal Obstruction .....Dr. J. H. Blackburn
Appendicitis .....Dr. A. T. McCormack
Peritonitis .....Dr. T. W. Stone

POST GRADUATE COURSE.

October 16, 1906, *at* 8 *p. m.*

Anatomy of the Female Pelvis.....Dr. Lillian H. South
The Mechanics of Normal Labor .....Dr. W. A. Briggs
Diseases of Pregnancy, Diagnosis and Treatment, Dr. W. H. McCracker

POST GRADUATE COURSE.

October 23, 1906, *at* 8 *p. m.*

How to Diagnose the Presentation .....Dr. Lillian H. South
Diagnosis, Treatment and Prevention of Septic Infection,.....
.....Dr. W. H. Thomas
Mechanics and Management of a Breech Presentation, Dr. E. A. Cherry
Management of a Shoulder Presentation .....Dr. B. S. Rutherford

POST GRADUATE COURSE.

October 30, 1906, *at* 8 *p. m.*

Eclampsia-Diagnosis, Prevention and Treatment....Dr. T. W. Stone
Placenta Previa .....Dr. A. T. McCormack
Prolapsus Funis .....Dr. J. F. Rogers

We call attention to the For Sale ad. of Dr. Ira J. Sellers in this issue. Any one wanting an x-ray coil should call on or write Dr. Sellers.

Upon invitation of the State Legislature Dr. J. N. McCormack of Kentucky, the Chairman of the Committee on Organization of the American Medical Association, addressed the joint session of that body on Thursday, Jan. 10th.

The Chattahoochee Valley Medical Association met in Alexander City, Ala., January 8th and 9th. Among those in attendance were Drs. W. H. Hudson, of Montgomery; J. P. Watkins and W. P. Lane, of Opelika; C. K. Maxwell, of Kelleyton; A. L. Moon, of Goodwater; G. C. Rudford and J. A. Chapman, of Tallapoosa county, besides the local physicians of Alexander City.

The following bills have been introduced in the House by Mr. S. W. John of Jefferson and referred to the Committee on Public Health, viz:

H. B. 32. To establish reformatories for inebriates, under the government of trustees of the Alabama Insane Hospitals, to regulate the admission of inebriate persons therein, their treatment and discipline therein, and their discharges therefrom; and to appropriate $50,000 to erect, furnish and equip the necessary additional buildings therefor.

H. B. 33. To establish a State sanitarium for the study of tuberculosis, and the best methods of preventing its spread and for disseminating the results of such investigations, and for the treatment of persons suffering therefrom.

Personal Notes.

Dr. Mack Rogers is out again after a short illness.

Dr. W. T. Cocke has moved from Hargrove to Livingston.

Dr. L. G. McCollum, of Birmingham, is visiting relatives at Marion, Ala.

Dr. J. T. Miller, of Short Creek, visited Birmingham during last week.

Dr. W. J. Winter has moved from Watertown, Tenn., to Hargrove to practice medicine.

Dr. Frank G. Grace, of Birmingham, was married on January 9th to Miss Kate C. Buchanan, of Birmingham.

Dr. and Mrs. S. L. Ledbetter, of Birmingham, celebrated their twenty-fifth wedding anniversary at their home on the evening on January 11.

Dr. Gaston Torrance has returned to his home in Birmingham after several months absence doing post-graudate work in the medical centers of Europe.

Dr. J. I. Reid, of East Birmingham, has moved to Aldrich, Ala., to engage in the practice of medicine in that place.

Dr. T. C. Donald, of Bessemer, Ala., and Miss Marie Melton, of Pine-apple, Ala., were married in Pine apple on December 12th.

Governor Comer has appointed Dr. W. A. Burns, of Sheffield, as medical convict inspector to succeed Dr. Nat. G. Clark, of Ensley.

The friends of Dr. E. H. Sholl, of Birmingham, are glad that he is able to resume his professional work again, after having been confined by a recent illness of a few weeks' duration.

The wife of Dr. James T. Searcy, Superintendent of the Bryce-Insane Hospital, of Tuscaloosa, died of paralysis on January 11th. We extend sympathy to the bereaved family.

Dr. T. F. Huey, formerly of Blocton, Ala., has located in Anniston, Ala., and associated himself with Dr. A. A. Greene, who makes a specialty of diseases of the eye, ear, nose and throat.

Dr. J. C. Walker, of Birmingham, and Miss E. I. Winter, of Lebanon, Tenn., were married in Lebanon, Tenn., on January 15th. After taking a trip to New Orleans and other Southern cities they will be at home February 1st at 1616 11th ave., N., Birmingham.

Abstracts.

A NOVEL METHOD OF USING STRYCHNINE AND HYDRASTINE IN SEXUAL AND VESICAL WEAKNESS.

And after many theoretical considerations and practical trials I have elaborated a plan which is giving me and my patients extreme satisfaction. The plan is very simple and consists in depositing a solution of strychnin by the aid of a Guvon syringe into the urethra, either just within the vesical sphincter or anteriorly to it, into the posterior urethra. But before giving the exact technic, I will state that I found a combination of strychnin with hydrastin much more efficient than the strychnin alone. The hydrastin exerts a distinctive curative action on the catarrhal or slightly congested condition of the urethral mucous membrane; its action is particularly marked when the vesical or sexual weakness is the result of chronic gonorrheal urethritis; but even when due to other causes the action is remarkably beneficial. The combination I have been using for several years is as follows:

Strychinæ sulphatis	gr. i	06
Hydrastinæ hydrochloridi	gr. x	6
Sol. acidi borici saturatæ	400 drops.	

One minim of this solution represents 1/400 grain of strychnin and 1/40 grain of hydrastin.

I have the patient urinate, wash out the urethra with a boric acid solution of oxycyanid of mercury. I fill up the Guyon syringe, attach the properly sterilized Guyon catheter, screw down the piston until a drop appears at the opening, and introduce it into the urethra to the spot where I want to deposit the solution. By turning the screw I deposit just as many drops as I wish to. Each turn of the screw corresponds to one drop. I seldom use more than 4 drops, corresponding to 1/100 grain of strychnin and 1/10 grain of hydrastin. And with this small dose, administered once or at the most twice a week, I accomplish more

definite positive results than with 1/20 grain of strychnin by the mouth three times a day and every day in the week. In other words, I accomplish with 1/100 to 1/50 grain strychnin given endorrethrally more than with 1 to 2 grains administered by the mouth. And, besides, I have no affect-effects. None of the undesirable accompaniments of strychnin which I have enumerated have ever made their appearance.

I do not wish it understood that this is the only combination I use. I sometimes combine the strychnin and hydrastin with ergotin, sometimes with adrenalin, sometimes with both. I also use other combinations and I do not give them here in detail because the object of this paper is not to present a detailed treatment of vesical and sexual weakness. My sole object is to call attention to the medical treatment of a class of diseases which are very often obstinate and in which internal treatment is either unsatisfactory as to results or as to undesirable by-effects.

Are there any cases in which this local instillation is inapplicable? I have not come across any. There is a small percentage of patients in whom the slightest manipulation of the urethra with the softest catheter, the instillation of a drop of water in the posterior urethra, will cause pain, spasm and even fever. In such cases a local anesthetic occasionally becomes necessary.

I do not use cocain in the urethra, have not used it for years, since a disagreeable experience in which I had nearly lost a patient. I use some of the well-known substitutes for cocain, my favorites being the lactate of benzoyl-vinyl-diacetone-alkamin or the hydrochlorid of benzoyl-tetramethyl-diamino-ethyl-isoprophylic-acohol.

I have also used strychnin and hydrastin in the form of rectal suppositories. The results, while not equal to those obtained by the local instillation of the alkaloids, are still very good. It is well to bear in mind, however, that the rectal dose of strychnin is, by exception, smaller than the dose by the mouth. A great portion of the strychnin becomes destroyed in the gastrointestinal canal and only a small percentage remains unchanged to exert its physiologic effect. This is not the case when the strychnin is exhibited by the rectum, and 1/100 grain of that

alkaloid by the rectal route has a better effect, and without any drawbacks, than 1/40 or even 1/30 of a grain administered by the mouth.—William J. Robinson, M. D., New York, in Journal A. M. A.

DERMATOLOGICAL AXIOMS.

1. In all cases of protracted eczema appearing abruptly during the period of senility and accompanied by furuncular lesions and intense subjective symptoms, without any appreciable cause to account for it, we should always be on guard for mycosis fungoides, one of the most dangerous cutaneous affections known.

2. Dry sulphur dusted in the clothing and bedding of individuals suffering from scabies effects a cure speedier than the various fatty preparations of the same agent.

3. In all cases of cutaneous affections direct the patient to refrain from the use of the four dietetic "p's"—pork, pickles, porridge, and pastry.

4. Do not use water in acute skin diseases, for pure water is extremely irritating during this stage of the malady, while its value in all cases of chronic cutaneous disorders cannot be overestimated.

5. In all cases of puritus ani examine the rectum for the presence of lesions, for not infrequently we encounter hemorrhoids and fistulæ as potent underlying factors of pruritus of the anoischial region. In all cases of pruritus of the scrotum, where parasites, both animal and vegetable, can be readily excluded, examine the urine for traces of sugar.

6. Do not give arsenic continuously for any considerable length of time, for it has been known to produce intense pigmentation of the covered regions of the body.

7. Chrysophanic acid in psoriasis is one of the most valuable therapeutic agents extant in the treatment of this disease. The reason that not all physicians meet with success may be found in the unsatisfactory and fluctuating efficacy of that drug, as well as in the unsettled manner it is employed. When used in ascending or gradual

strength and a good acid of known quality is selected, the most gratifying results can be confidently anticipated.

8. Never examine cutaneous lesions of the fingers and hands without having recourse to a magnifying glass. The latter will tend to elicit the burrows of scabies, for instance, which the naked eye will have difficulty in detecting. Moreover it will aid in the finding of ova of pediculi clinging to the pubic hairs, which are only too frequently overlooked on a cursory examination.

9. Iodine is invaluable as a remedy in a number of instances, but its promiscuous and unintelligent use, especially on the extremities, will not infrequently give rise to erythemata of various type, prominently that of the multiform variety.

10. Yellow, elevated lesions beneath the inferior eyelid or at the inner canthus suggest xanthoma, and denote either hepatic derangement or a glycosuric condition.—Aronstam in Medical Monitor.
Gal 1—Medical Journal

PNEUMONIA AND GRIPPE.

Albert Woldert has had the opportunity of carefully studying cases of croupous pneumonia and grippe in a small rural district. From his observation he has drawn various conclusions, among which are the following: While grippe appears to be an infectious disease, not all of those who come in direct contact (such as sleeping in the same bed) contract the disease. The possible average period of incubation by air transmission is about seven days. One suffering with grippe should be warned against the tendency to develop pneumonia. Proper care should be exercised to destroy all sputa and fommites which may aid in the spread of grippe. Infection of the human system by the bacillus of grippe so lessens the natural immunity, or prepares the soil of man, that subsequent infection by the virulent diplococcus of pneumonia and consequent production of croupous pneumonia may more readily occur. The possible average period of incubation of croupous pneumonia by air transmission is about ten days.—Medical Record, January 5, 1907.

THE STEM PESSARY.

In a paper on the Stem Pessary for Amenorrhea and Dysmenorrhea in the Journal A. M. A., J. H. Carstens, M. D., gives the following as his conclusions:

1. The stem pessary will generally cure amenorrhea after all other means have failed.

2. It will develop an infantile uterus, enlarge a prematurely atrophied one, and restore a superinvolutional womb to a normal condition.

3. It will cure most cases of intractable dysmenorrhea, when no special pathologic condition can be found.

4. If worn for six months or a year it sometimes cures sterility.

5. All inflammatory conditions about the pelvic organs must be rigidly excluded before it is used. The same septic precautions should be taken during its introduction as a surgeon would take with the most complicated case of abdominal surgery.

SCIENCE AND MEDICINE FOR AUTUMNAL COUGHS AND COLDS.

Have your patient bathe the feet in hot water before retiring and drink a pint of hot lemonade. Two Antikamnia and Codeine Tablets taken with the lemonade will quiet the nerves, produce sleep and help break up the cold.

Patients should be advised, when tempted to cough, to take a deep breath, filling every air cell, holding it until the warming, soothing effect comes, or so long as is reasonable, and mark the mollifying result on the cough, which, even when the cough seems unavoidable, will often be found under control. It will help to minimize the cough and in the milder cases will stop it altogether after a little perseverance. The explanation of this is that there is a liberation of nitrogen in the air cells, wh ch has a quieting effect on the irritated mucous membrane.

If the cough is persistent or deep-seated and especially if it is annoying at night, one Antikamnia and Codeine Tablet slowly dissolved in the mouth, will quiet the nervous tickling and stop the cough.

INSURANCE EXAMINATIONS.

Commenting upon the effort of the insurance companies to cut the rates to be paid doctors for examinations of prospective policy holders, a correspondent calls attention to the peculiar fact that this should come at just the time when prices of everything have advanced, and when it costs the physician, as well as everyone else, more than ever to feed, clothe and house his family. Another fact is called up, namely, that most of the companies that have resorted to this questionable measure for economizing, have been shown up in a poor light, when they have been examined. As a rule, the business men with whom the physician does business, fix their charges for the goods they have to sell. The physician does not go to the railroad company and tell how much he will pay for a ticket to a proposed destination; nor to the grocer and tell him how much he will pay for the groceries he needs at his house. There should be a mutual understanding between the insurance companies and the physicians as to the price to be charged by the latter for examinations, and if it takes something of the trades union order of things to secure this mutual understanding, then that is what should be called into use. Locally, the profession has not sufficiently come together on this point to carry its point, and some of the companies seem to be willing to resort to any methods in order to get cheap service. They should be properly exposed, and it is the duty of the local society to do the work.—Medical Sentinel.

THE TRYPSIN TREATMENT FOR CANCER.

Jere L. Crook, A. M., M. D., of Jackson, Tenn., in Southern Medicine and Surgery says concerning the trypsin treatment for cancer:

Additional experience with Trypsin in the treatment of inoperable cancer has stil further confirmed my faith in the theory upon which the treatment is based. I am pleased to report that my patient, whose life tenure has long since expired, according to the ordinary course of this malady, is still living in comfort, surrounded by her family. On Dec. 3rd she was able to walk out on the veranda and sit for a while in the sunshine.

I used the Trypsin injections regularly on alternate days for two months; then used amylopsin alternately with the Trypsin for one month; then left off both for three weeks. After leaving them off she failed, her general condition became much worse, appetite departed. nervousness and pain increased, and the cancerous ulcer, which had diminished 50 per cent. under the Trypsin, enlarged rapidly. Two injections given during the three months were followed by pain and inflammation, but not to the point of suppuration, and for this reason some members of the family wished them left off. Since resuming the injections two weeks since, every symptom has improved and the ulcer has again diminished greatly.

I believe that Trypsin has prevented the occurrence of secondary cancer. I know it has caused a marvelous improvement in the local ulcer, and has kept the disease at a standstill for several weeks.

Moreover, notwithstanding the fact that this case was regarded as inoperable by three of the most eminent surgeons in America last May, yet the patient is living in comparative comfort on December 5th; requiring during twenty-four hours only 1-4 grain morphia and 3 grains of codeia to keep her entirely free from pain.

If her present condition be not due to the beneficent influence of the Trypsin, I am unable to account for it. If it accomplishes (as I believe it has in my case) the three-fold work of preventing secondary involvement, lessening human suffering and lengthening human life, it is a great boon to humanity, even if it never accomplishes a complete cure.

STATUS OF SCOPOLAMIN-MORPHIN ANESTHESIA.

Deeson, Miss., Dec. 21, 1906.

To the Editor:—Will you kindly give the status of scopolamin anesthesia? In the last edition of Wood's Therapeutics it is stated that from the reports of nearly 2,000 cases collected by H. C. Wood, Jr., the mortality was 9, or 1 in 221; and that in 69 per cent. of the cases ether or chloroform had to be given to complete the operation. In this work this method of producing anesthesia as a routine measure is very strongly condemned. In The Journal, Aug. 25, 1906, advertising page 25, appears an advertisement of the Abbott Alkaloidal Co., in which the morphinscopolamin method of producing anesthesia is extolled in extravagant and alluring language, making use of the following expressions: "Painless surgical practice without chloroform or ether and without nausea or post-operative emesis accomplished with hyoscin-morphin and cactin comp. (A. A. C.). No anesthetist required. Not one failure or unpleasant symptom has been reported. It is a powerful and efficient combination, and is indicated in major surgical and gynecological operations in lieu of the common general anesthetics." No one but a country physician, practicing in sections remote from efficient aid, can appreciate the enticing persuasions of this advertisement. Either Prof. Wood is in error or the alkaloidal people are in error. I am all at sea, because, living among our "colored brethren" as I do, my emergency work at this season of the year is considerable; and if I could feel safe in the employment of this method it would indeed be a great boon. Thomas J. Ray.

Answer.—This letter was submitted to Dr. Wood, who made the following reply:

"While it is not flattering to a pharmacologist to have his conclusions called in question on account of the extravagant language of the advertisements of drug manufacturers, as the question is one of some importance I am pleased to have an opportunity of re-asserting my convic-

tions as to the danger of scopolamin-morphin anesthesia, and the reasons for my belief. In the first place, it must be remembered that scopolamin is simply a new name for hyoscin. It has been asserted that although there is no chemical distinction between the two alkaloids they are obtained from different plants. This, however, is a mistake. The definition of the U. S. Pharmacopeia admits of either hyoscin or scopolamin being made from any plant belonging to the family of *Solanaceoe,* provided it answers to certain chemical tests, which tests are precisely the same for scopolamin as for hyoscin. The German Pharmacopeia no longer recognizes the name hyoscin. The recognition of the two names for one substance by the U. S. Pharmacopeia is unfortunate, as likely to lead to confusion. If the physician who is meditating the comparative value of the hypodermic anesthesia will bear in mind that the two agencies employed are morphin and hyoscin he will be able to gauge the effect which may be expected. Hyoscin has practically no power as an analgesic, and differs from the other mydriatic alkaloids in being depressant and not stimulant to the respiratory center. The addition of hyoscin to the morphin, therefore, can not greatly increase the insensibility to pain, but must distinctly augment the liability to respiratory failure.

"The statement quoted that: 'Not one failure or unpleasant symptom has been reported,' is separated from falsehood only by the width of the advertiser's license. In*American Medicine,* 1906, page 546, I have considered in some detail the reported cases in which, this method of anesthesia has been employed. In 1988 cases there were reported 23 deaths, of which after careful study of the original records at least 9 seem to me may be fairly attributable to the anesthetic. There were also 868 cases in which the anesthesia was unsatisfactory, and in a number of cases besides these no attempt was made to produce complete anesthesia without the use of ether or chloroform. There is little room for doubt that the previous hypodermic administration of morphin will lessen the quantity of ether or chloroform necessary to produce anesthesia, and in many cases also lessen the unpleasant symptoms of the anesthesia; but that the danger of the narcosis is in anyway diminish-

ed by this practice I think is exceedingly questionable, and the admission of sufficient quantity of morphin to produce complete anesthesia under ordinary circumstances seems to me inadmissible. The role of the hyoscin or scopolamin in the anesthesia is entirely subsidiary to that of the morphin. When one considers that in 2,000 cases of this form of anesthesia 9 deaths have occurred and compares these figures to 1 death in 16,000 for ether he will hardly dare weigh the question of convenience against this frightful mortality."—Jour. A. M. A.

DISINFECTION BY FORMALDEHYD.

Muskogee, I. T., Dec. 14, 1906.

To the Editor:—Please state the best method of disinfecting rooms after scarlet fever. Please also give the proportions and quantities of formaldehyd and solution of permanganate of potash for 1,000 cubic feet of air space. J. W.

Answer.—For each 1,000 cubic feet of air space five or six ounces of crystals of potassium permanganate should be placed in the container. Over it should be poured one pint of 40 per cent. solution of formaldehyd. The air in the room must be moistened, or disinfection will not be complete. The air may be moistened by wet sheets, hung about the room, before the disinfection takes place. This method of disinfecting was described in The Journal, July 14, 1906, pages 139. In a letter published July 28, page 288, Dr. Henry Albert, Iowa City, Iowa, discusses the proportions of the ingredients, a subject which he further takes up in a recent issue of the *Iowa Health Bulletin.* Dr. James A. Egan, Springfield, Illinois, discusses the matter further, August 18, page 523. A report of a detailed comparison of the various means of disinfecting was reviewed in The Journal, September 22, page 952. The objection most commonly raised against formaldehyd as a disinfectant is that it has little or no penetrating power. In the experiments of the Illinois State Board of Health, however, it has been shown that when the gas

is generated by the formaldehyd-permanganate method this objection does not hold. It destroys micro-organisms through four layers of flannel and two layers of sheets, but the disinfection failed when cultures were enclosed between the leaves of books and was not satisfactory when placed beneath a carpet. The inside of a closed drawer was disinfected, even though it was a dead space, there being no artificial means of putting the air in motion. To ensure penetration the gas should be generated in an approved manner so as to secure a large volume of gas and a long exposure. Some experiments made in the Hygienic Laboratory of the United States Public Health and Marine-Hospital Service indicate that the effectiveness of formaldehyd depends largely on the temperature and the degree of humidity. The experimenter, T. B. McClintic, concludes that this gas is not to be relied on if the temperature is below 60 degrees F, and if the relative humidity of the atmosphere is less than 65 per cent. *The Bulletin of the Illinois State Board of Health* (November-December, 1906) criticises these conclusions on the ground that the apparatus used was not the best, the pail having straight sides instead of a flaring top and not being covered with asbestos, the amount of gas evolved being too small and being allowed to escape, as the room was not sealed. Experiments instituted by the Illinois board showed that the disinfection can be made effective in cold and dry weather by attending to these details.—Journal A. M. A.

THE PURE FOOD BILL.

The Pure Food Bill, having been successfully steered through the shoals of the National Congress, and the appropriation for its enforcement being expected to be duly passed at the next session, we shall soon have an opportunity of wondering how the country jogged along before it became a *fait acccompli.*

Upton Sinclair's terrific sociologist novel, "The Jungle," arrived at the psychological moment. The new regulations for the inspection of meat products for interstate and foreign trade provide for a very thorough upheaval in abatoir methods. The sanitary cleanliness of

premises and employees is specifically ordered. There shall be daily cleansing and inspection of trucks, and implements of all kinds. Toilets must be isolated from rooms where cattle are dressed. Employees suffering from tuberculosis are to be excluded. No food product shall contain preservatives other than those permitted: common salt, sugar, wood smoke, vinegar and pure spices. Animals suspected to be diseased shall be slaughtered in a separate house in the presence of a federal inspector. Waste parts considered unfit for food shall be destroyed. Strict provision is made for proper labeling of marketed goods. When the legend, "U. S. Inspected and passed," is affixed, it means Uncle Sam's statement that the product is wholesome and sound, and contains no dyes or preservatives which would render it unclean, unfit, or unhealthful. Finally, the attempt to bribe an inspector and the reception of any consideration by an inspector are made felonies.

The drug provisions in the Pure Food Bill are aimed at securing honest ingredients and proper labeling. The seductive soothing syrup and the liver medicine and the spring tonic and the bowel regulator *et id omne genus* will have to state on the label the percentage of alcohol, narcotics, and poisons generally, that they contain. Their sale is stopped so long as they fail to comply with these requirements. The public is safeguarded simply to the extent of knowing what they are swallowing. Now, as before, "You pays your money and you takes your choice," but you know what you are getting.

All this sounds good, and the effectiveness of the regulations will be closely watched. Let us hope that our poor soldier boys will get no more embalmed beef when next their country calls them, and let us feverently hope that there shall be no more of the days when

Little Jack Horner
Sat in the corner
Eating a packing-house pie;
He put in his thumb
And pulled out a

Piece of rope, two chunks of bone, three fish-hooks, a pair of suspenders, a gum shoe, a pajama pants, three collar buttons, a lottery ticket, a sample of dress goods and a safety razor.—*The Georgia Practician.*

Book Notices.

GOLDEN RULES OF PEDIATRICS.—Aphorisms, Observations and Precepts on the Science and Art of Pediatrics; Giving Practical Rules for Diagnosis and Prognosis, the Essentials of Infant Feeding, and the Principles of Scientific Treatment. By John Zahorsky, A. B., M. D., Clinical Prof. Pediatrics, Washington University Medical Department, St. Louis; Ex-Pres. of the Bethesda Pediatric Society; Attending Physician to the Bethesda Foundlings' Home; Member of the American Medical Association and of the St. Louis Academy of Science; Editor of the St. Louis Courier of Medicine; Author of "Baby Incubators," etc. With an Introduction by E. W. Saundes, M. D., Prof. of Diseases of Children and Clinical Midwifery, Washington University, etc. Price $3.00. The C. V. Mosby Medical Book Co., St. Louis, 1906.

This is an attractive book of 362 pages, in which the author claims originality for the mode of presenting the knowledge conveyed in it, which he says is the knowledge of the profession. It is a collection of precepts or propositions of the author's selection for the guidance of the physician in the practice of pediatrics. A few of the precepts will best illustrate the author's plan, which we take from the Subject of Artificial Feeding.

The golden rules of artificial feeding are absolute cleanliness in the handling of the milk, and regularity of feeding. Do not overfeed the infant. Do not dilute the milk too much; remember that an infant four months old often thrives on pure cow's milk. The best substitute for mother's milk is fresh, clean, cow's milk. Do not be deceived by the literature of patent food manufacturers.

Cow milk is preferable to pasteurized or sterilized milk, if the milk is clean and fresh.

The death rate of infants fed on condensed milk is fifteen per cent.

higher than those fed on fresh milk; therefore do not recommend this food except for temporary use, when fresh cow's milk is obtainable.

Remember that the simple dilution of cow's milk (three parts of water and one part of milk) with the addition of five per cent. of sugar, makes a better food than condensed milk. The French and German authorities even today use simple dilutions of milk. A common rule is as follows: For a baby during the first month, three parts of water, one part of milk; infant two months old, equal parts of water and milk; infant three or four months old, three parts milk and one of water; older infants are fed on pure cow's milk.

PRACTICAL DERMATOLOGY.—A Condensed Manual of Diseases of the Skin; Designed for the use of Students and Practitioners of Medicine by Bernard Walff, M. D., Clinical Professor of Diseases of the Skin in the Atlanta College of Physicians and Surgeons; Editor of the Atlanta Journal-Record of Medicine; Ex-President of the Atlanta Society of Medicine; Ex-Secretary of the Georgia State Commission on Tuberculosis, etc. Illustrated. Chicago: Cleveland Press, 1906.

The author states the purpose of this volume to be to present in miniature the salient features of diseases in the skin, and that in its preparation the standard text-books as well as the smaller manual have been freely consulted and the latest and most authoritative views concerning the origin, course and treatment of the diseases considered are briefly and consisely stated.

The book is divided into three sections. The first Section is the introduction and describes the anatomy of the skin, general symptomatology, diagnosis, etiology and treatment, with a general classification of skin diseases.

The second Section takes up special diseases of the skin, giving the definition and description, the etiology, pathology, symptoms, diagnosis, treatment and prognosis, etc., of each.

The third Section is made up entirely of formulae for the treatment of the different diseases of the skin.

The book is neatly bound and contains numerous illustrations, and will no doubt prove helpful to both the student and the general practitioner.

A Compend of Operative Gynecology based on Lectures in the Course of Operative Gynecology on the Cadaver at the New York Post-Graduate Medical School and Hospital. Delivered by William Seaman Bainbridge, M. D., Adjunct Professor of Operative Gynecology on the Cadaver, New York Post-Graduate Medical School and Hospital; Consulting Gynecologist, St. Mary's Hospital, Jamaica, L. I.; Consulting Gynecologist to St. Andrew's Convalescent Hospital, New York, etc. Compiled, with Additional Notes, in Collaboration with Harold D. Meeker, M. D., Instructor in Operative Gynecology on the Cadaver, New York Post-Graduate Medical School and Hospital; Assistant Department of Gynecology, Vanderbilt Clinic, College of Physicians and Surgeons, New York. 12mo cloth, 76 pages. Price $1.00 net. The Grafton Press, Publishers, New York City.

Consolidated Report of the Trustees of the Alabama Insane Hospital —The Bryce Hospital, Tuscaloosa, Ala., and The Mt. Vernon Hospital, Mt. Vernon, Ala. For the years 1903, '04, '05 and '06. This contains also a paper on "Mental Abnormalities" by Dr. J. T. Searcy, Superintendent The Alabama Insane Hospitals. Hospital Print. 1906. Paper.

Requirements of the Mosquito Doctrine, Yellow Fever in New Orleans in 1905. By Sidney L. Theard, A. M., M. D., Sanitary Officer and Secretary of the Board of Health of the City of New Orleans; formerly Assistant Sanitary Inspector to the Louisiana State Board of Health, etc. Reprinted from New Orleans Medical and Surgical Journal. November, 1906. Paper.

Bulletin No. 138, December, 1906, Alabama Agricultural Station of the Alabama Polytecnic Institute, Auburn, Ala. Variety Tests with Cotton and Corn. Williamson Method of Corn Culture. By J. F. Duggar, Director, and L. N. Duncan, Assistant in Agriculture. The Post Pub. Co., 1906. Paper.

Simplified Course of Instruction on Refraction. By R. S. Piper, M. D. Four Books, containing Ten Lessons. Each Book has sealed questions for examination, making it serve as a Correspondence Course. Paper. Price complete $5.00.

Transactions of the Third and Fourth Conferences of State and Territory Health Officers with the United States Public Health and Marine-Hospital Service. Washington, May 15, 1905, and May 23, 1906.

Thirteenth Annual Report of the Craig Colony for Epilectics at Sonyea, N. Y. Adopted by the Managers, Oct. 9, 1906. Paper. Pp. 106. 25 Illustrations.

VALUE OF THE LEUCOCYTE COUNT.

Frederic E. Sondern says that his continued daily contact with cases in which the diagnostic aid of the differential leucocyte count is sought strengthens rather than weakens his belief in this valuable factor in surgical diagnosis. It presents diagnostic and prognostic data at a time when the clinical picture may be confusing. While it is true, continues the writer, that pitfalls and errors surround this as they do all other diagnostic methods, and while it is of use to only the discriminating clinician who learns to apply it, still nobody can gainsay the fact that it fills a place occupied by nothing else. A few examples which emphasize this point are then quoted.—Medical Record, December 22, 1906.

Miscellaneous Notes.

The disclosure in the recent past of the fact that many preparations contain opiates or other habit-forming or depressant drugs has no doubt cast suspicion more or less upon all preparations, whether deservedly or not, especially upon those intended for nervous conditions. Neurilla has always been and is now free from "dope" of any kind, and the National Pure Food and Drugs Act should have the effect of reassuring any physician of doubtful mind regarding Neurilla, as we would scarcely guarantee such a statement in the face of the law.

Dad Chemical Company.

Physicians who are interested in the study and legitimate practice of the physicial (drugless) therapeutic methods, notably electro-therapy, photo-therapy, mechano-therapy, hydro-therapy, suggestion and dietetics, are invited to join the American Physio-therapeutic Association. Address the Secretary: Dr. Otto Juettner, No. 8 W. Ninth St., Cincinnati, Ohio.

The officers for the ensuing year are: President, Dr. H. H. Roberts, Lexington, Ky.; Secretary, Dr. Otto Juettner, Cincinnati, Ohio; Treasurer, Dr. Geo. H. Grant, Richmond, Ind.; Executive Council, Drs. W. F. Klein, Lebanon, Pa.; Jas. Hanks, Brasher, Mo.; J. W. Unger, West Point, Miss.; Chas. S. Northen, Talladega, Ala.; R. W. Gibbes, Columbia, S. C.; S. J. Crumbine, Topeka, Kans.; A. L. Blesh, Guthrie, Okla.

"At the regular meeting of the Second Section of the American Urological Association, held in New York on Wednesday, October 24th, 1906.....

"The President, Winfield Ayres, M. D., officially announced the death of the Vice-President of the Second Section, William K. Otis, and called for a report by the Committee appointed for the purpose, to present a memorial on the Association's bereavement. In presenting the report, a member of the Committee said:

"The ties of life-long intimacy which bound most of us to Dr. Otis, make his death a subject of grief to each individual. The usual set form a preamble and resolutions, therefore, were deemed inadequate by your Committee to express our sorrow. 'Billy's' demise is, to the older members of the Association as if a much loved brother had gone from us. Your Committee begs to submit:

William Kelly Otis' earthly career ended on September 22nd, 1906.

To the members of the American Urological Association, his death is a threefold blow.

Most of us knew him intimately from his childhood; by his decease we lose a consistent friend, a charming companion, a most estimable colleague.

To the Science of Urology his death means an irreparable loss. Cut off in the midst of his career, his inventive genius is stopped; the new and useful instruments he was continually devising must now be perfected by other hands. The advances in our work, he can no longer aid in developing.

The American Urological Association loses one of its founders, one of its active coadjutors, one of its truest adherents.

Our Association shares with the family of William K. Otis, with the Profession at large, and with that world in which true manhood is understood and appreciated, that deep grief which the death of so noble a character inspires.

Ramon Guiteras,
A. Ernest Galliant,
Ferd. C. Valentine,
Committee.

"Follen Cabot, M. D., moved, and G. K. Swinburne, M. D., seconded that the report be accepted and the Committee discharged. Carried.

"Augustin H. Goelet, M. D., moved, and George M. Muren, M. D., seconded, that the introductory remarks with which the memorial was presented, together with the memorial, be spread upon the minutes, published in the medical journals, and a copy furnished the family of the deceased. Carried.

"The President appointed Ferd. C. Valentine a Committee with full powers to execute the behests of the above resolutions."

A true copy from the minutes.

Winfield Ayres, M. D., Pres. W. S. Reynolds, M. D., Sec.

A TRUE CALMATIVE.

For many years physicians have desired a calmative that would give satisfactory results in quieting and toning the nervous system, without the weakening after-effects that characterize the opiates and the ordinary sedatives on the market. In Daniel's Passiflora Incarnata, this quality has been discovered and for this reason alone, it should appeal strongly to the practitioner, because a prompt and valuable calmative is indispensible to every practice. Daniel's Passiflora is prepared from the green May-pop and embraces in concentrated form, the medical properties of this plant. It, therefore, is indicated in every form of nerve debility, from nervous headache to incipient insanity.

For nervous women, during the menstrual period pregnancy and the menopause, for teething babies and in hysteria, insomnia and Neuralgia, Daniel's Passiflora exerts a soothing and curative influence and overcomes irritation, reduces tension and restores the nervous system to a normal and healthful condition.

SPRAYING FOR DISEASES OF THE RESPIRATORY PASSAGE.

Dr. David Walsh, senior physician to the Western Skin Hospital, London, writes: Glyco-Thymoline was brought to my notice as an excellent lotion for nasal and oral sprays and washes. On due inquiry it was found to fulfil the two conditions usually recognized by medical men in the United Kingdom as vouching for the character, so to speak, of such a preparation. First, its advertisements are accepted by our three leading journals, the Lancet, British Medical Journal and the Medical Press & Circular. Secondly, its composition is not a secret, its formula being freely published. Under these circumstances I determined to try the effect of this preparation in a few suitable cases. As

a general antiseptic that does not coagulate albumen and is non-irritant, deordorant and practically non-poisonous, Glyco-Thymoline has clearly a wide range of usefulness. My own observations, however, have been practically confined to its use in the nose and mouth, with results that have proved satisfactory in every instance, especially in acute coryza, pharyngitis, influence and septic conditions of the mouth.

PNEUMONIA FOLLOWING STAB-WOUND.

By J. A. Davis, M. D., of Norman, Oklahoma.

On January 11, 1905, Mr. C., aged 20, was stabbed in the back below the scapula, and when I saw him twenty minutes ofter the affray, he was suffering from profound shock. I carried out the usual operative procedures, and the patient rallied, doing well until the night of the eighth day, when he had a severe chill, presaging pneumonia.

I feared a fatal result, as the left pleural cavity contained considerable bloody serum, and immediately applied a thick dressing of ANTIPHLOGISTINE 10 inches wide, from the spinal column to the median line, in the front, and kept up this treatment for three weeks, changing the dressing every morning. By this time the lung was perfectly clear, and there was no further use for the external application.

The ANTIPHLOGISTINE was covered by a cotton jacket and held in place with a cloth bandage. The pain was relieved by hypodermics of morphine and atropine and the heart was sustained by strychnine. Outside of a little calomel and some laxatives, there was no other treatment. I aspirated the pleural cavity and drew off the serum. In view of the complications in this case, I considered it rather remarkable that the patient made so excellent a recovery. It only confirms my own high opinion of the remedial value of ANTIPHLOGISTINE.

"SPINAL CORD COMPLICATIONS OF ANEMIA."

With increased knowledge of the anatomy and physiology of the brain and spinal cord, there is growing opinion among careful clinical observers that many of the nervous phenomena accompanying general anemia can be directly attributed to resulting changes in the nervous system.

The spinal cord complications of pernicious anemia have been recognized for some time, and it is no uncommon thing in these cases to find pronounced degenerative areas throughout the cord. The posterior columns and occasionally the lateral are most often involved, the nerve fibres being chiefly affected, without however, the extreme shrinking usually observed in locomotor ataxia. While there can be no doubt that these conditions depend to a certain extent on the blood changes incident to the anemic process, it is more than probable that the toxins resulting from the attending hemolysis exert direct injury on the nerve cells.

Fortunately the ordinary anemias are not attended by such extreme changes, and the resulting symptoms, with their speedy control under appropriate treatment, point to a functional rather than an organic origin. These symptoms, while extremely variable, usually consist of constant and pronounced backaches, especially in the spinal reflexes, paresthesias generally, and often times irritability of the anal or vesical sphincters. Headache is frequently complained of, although the patient is usually able to sleep. The symptoms referable to the sexual function are also extremely variable, especially in the female, and range all the way from absolute frigity to positive nymphomania.

Frequent reference is made to the heart by these anemic patients, and while their symptoms may be somewhat due to the changes in the blood current, there can be no question that the sympathetic nerves suffer in the general involvement of the nervous system, and may therefore be directly responsible for the arythmia, tachycardia, etc., so often complained of.

The great therapeutic value of Pepto-Mangan (Gude) is well shown by its rapid and pronounced action in these cases of anemia complicated by nervous derangements. With the rise in hemoglobin and the blood count, which immediately follows the administration of Pepto-Mangan (Gude), the backaches and headaches cease, the sensory disturbances disappear, and the patient's nervous system rapidly returns to the normal. The comparative ease with which these cases are restored to health when thus treated, will be exceedingly gratifying to the zealous

practitioner. He, more than anyone else, realizes the danger of letting young females thus afflicted drag along indefinitely, for he knows that the psychic influence of long continued sensory disturbance is extremely prone to develop and magnify any hysterical tendencies however latent. Early and efficient treatment is therefore not only desirable, but urgently necessary, and Pepto-Mangan (Gude) will never prove disappointing.

An epidemic of cerebro-spinal meningitis at Montgomery, Alabama, beginning in March, 1905, and not yet ended, has established mortality rate higher than the maximum stated by Ziemssen —the percentage of deaths being almost 73—78 deaths out of 107 affected. Aside from the very high mortality, this epidemic is interesting on account of the fact that it has offered an opportunity for careful bacteriologic investigation of many cases, resulting in general corroboration of the contention that the *diplococcus intracellularis meningitidis,* or *meningococcus* is the organism exciting the disease. Since 1887, when Weichselbaum first described this organism, various observers have continuously offered corroborative testimony, although a few prominent clinicians and bacteriologists have disagreed. Netter insisted that the *meningococcus* was merely a degenerate *pneumococcus* and Osler seemed to have thought seriously enough of Netter's contention to have stated that "primary cerebro-spinal meningitis may be due to the *pneumococcus.*" In the twenty-three cases studied by J. M. Mason, in the Birmingham epidemic, the *meningococcus* was present in 19 cases; the *tubercle bacillus* in 1 case; the *meningococcus* and *tubercle bacillus* in 1 case and the*pneumococcus* in 1 case. Mason disposes of the case in which the *tubercle bacillus* was the predominating bacterium, by stating that the meningitis was secondary to tubercular mesenteric glands, while the case in which the *pneumococcus* was the only bacterium found, he ascribes to a primary lobar pneumonia. If Mason is fair in thus explaining away the presence of the *tubercle bacillus* and *pneumococcus,* his observations strongly confirm the assertion that the *meningococcus* is the true etiologic factor.—The Chicago Clinic and Pure Water Journal.